EVIDENCE-BASED ADVOCACY FOR MATERNAL AND CHILD HEALTH OF URBAN POOR :
A Case Study from Vadodara, Gujarat

SWATI VYAS

Society for Health Alternatives (SAHAJ)

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Evidence Based Adv

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Table of Contents

CHAPTER 1. Urbanization and Health of Urban Poor 1

1.1. Urbanization 1

1.2. Urban Poverty 1

1.3. Health Status of the Urban Poor 2

1.4. Urbanization and Health Status of Urban Poor in Gujarat 3

1.5. Urbanization and Health Status of Urban Poor in Vadodara City 4

CHAPTER 2. Policy Environment for Reproductive and Child Health, Basic Services and Infrastructure Development in India 5

2.1. Reproductive and Child Health Policies 5

2.2. The National Population Policy (NPP 2000) 5

2.3. National Rural Health Mission (2005-2012) 6

2.4. National Urban Health Mission (NUHM 2008-2012) 6

2.5. Jawaharlal Nehru National Urban Renewal Mission (JNNURM) 7

2.6. SAHAJ's Analysis of the Policies 8

CHAPTER 3. Overview of SAHAJ-Shishu Milap 9

3.1. Children's Programme 11

3.2. Adolescent Development 11

3.3. Community Development 13

3.4. Maternal and Child Health 13

CHAPTER 4. Programme on Evidence Based Advocacy for Maternal and Child Health 14

4.1. Background 14

4.2. Programme Objectives 14

4.3. Methodology 15

4.4. Programme Implementation 15

CHAPTER 5. Evidence Based Advocacy 35

5.1. Evidence and Data 35

5.2. Advocacy for Health and Health Care as a Human Right 36

5.3. Advocacy Strategies adopted by SAHAJ 38

5.4. Impact of Evidence based Advocacy 42

CHAPTER 6. Challenges and Lessons Learnt 44

6.1. Challenges 44

6.2. Lessons Learnt 46

Annexures 48

Annexure 1 Media Clippings 48

Annexure 2 Glossary 51

References 52

Preface

In the discourse on access to health services, the urban poor are missed out. Urbanisation is an increasing trend as rural migrants, many of whom are poor, arrive in cities and towns for jobs and in search for a better life. Many of them however end up in slums, or poor shanties, where life is literally a hand to mouth struggle. Doctors are available and so are medical services. But they are costly and unaffordable and worse unreliable. The slum doctors are at best quacks and if qualified, they are qualified quacks: irrational practice abounds as much as exploitation. Lack of clean water, toilets and housing as much as illiteracy and lack of assured public health services are the cause and the problem.

If the urban poor seek some bigger names and private hospitals, the situation is probably no better. Here too irrationality abounds and this comes with a costlier price tag. Cut practice is rampant in laboratory, X-ray and CAT scan services as also in specialist referrals. There is seldom any prescription audit of specialist doctors.

All these create a dismal situation. We need rational therapy and low cost affordable health services: both clinical and para clinical.

SAHAJ Shishu Milap has been working in several bastis of Vadodara for the last 20 years. We started with an idea of working only in pre-primary and primary education – but we found unless we respond to other basic needs, education is an elusive goal. This document is a small report, ably captured by Swati Vyas, MPH (LSTM), of our efforts at providing some health services for the urban poor.

Such efforts as this report tries to outline are important especially in the context of the welcome National Urban Health Mission (NUHM). However as the report points out:

> *"While the NUHM analysis of the health situation for the poor urban, cannot be faulted with, the solutions proposed are not congruent with the analysis. The document is not convincing about how the increasingly invisibilised urban poor, will be identified and their health needs addressed. How will daily migrant wage labourers be reached out to? Those who have no rights to residence (those living in unauthorized slums, pavement dwellers, and such like) have a lot of difficulty accessing schemes and programmes meant for Below Poverty Line population – it is not clear how these difficulties will be addressed.*
>
> *NUHM states that the solution to 'where no government health facilities exist' will be*

empanelment of private doctors/hospitals. This is problematic because the existing pattern of empanelment in the Chiranjeevi Scheme, has not worked in urban areas – we can say this confidently about Vadodara, at least. Why does the government not commit to investing in public health facilities at the primary and secondary level in urban areas?"

The poor state of health services in rural areas has been attributed to the oft repeated statement "doctors do not go to rural areas." But in urban areas this presumably is not the problem. Why then does the Government not provide for urban health services in a concerted manner? NGOs like SAHAJ can only point out the way, but they are not the total long-term solution that the urban poor so desperately need.

We look forward to discussion on the issues laid out in the report.

Renu Khanna
Trustee, SAHAJ

Vadodara
June 2009

CHAPTER 1

Urbanization and Health of Urban Poor

1.1. Urbanization

According to the projections in the World Development Report 2009 "cities in developing countries will double in three decades, adding another 2 billion people." It has recognised the fact that urbanization will lead to increase in informal settlements and slums. The government's efforts in provision of infrastructure and housing facilities are inadequate in comparison to the rising population due to urbanization. In addition, the report also mentions that "trying to restrict rural-urban migration can be counter-productive. Because, limiting density and diversity stifles innovation and productivity." It further suggests that urbanization should be an inclusive process and urban policies should adopt the approach of integrating slums into the broader urban economy.[1]

Urban areas in India are rapidly growing with the current population of 286 million people as per 2001 Census and is estimated to increase to 432 million by the year 2021[2], thus putting greater strain on the urban infrastructure which had serious deficiencies already.[3] This has led to several gaps in availability of basic amenities in the urban areas. Internationally, India stands second after China among the worst places in the world with regards to total number of people lacking access to sanitation. 17.73 million (16.3 %) urban households do not have access to tap water and 7.26 million (10.78 %) urban households do not have access to any water for some parts of the year. 12.04 million (7.87 %) urban households do not have access to any latrine and defecate in the open.[4]

1.2. Urban Poverty

Poverty is not merely a rural phenomenon. The population of urban poor in India has been increasing with rapid urbanization. In 1987-88 urban poor population was 75.17 million (38.20 % of total population) which increased to 76.34 million (32.36 %) in 1993-94 and 80.80 million (25.70 %) in 2004-05.[4] Though the percentage of urban poor has been reducing over a period of time, the absolute number of poor has been increasing. The Task Force on Projection of Minimum Needs and Effective Consumption Demand (constituted by the Planning Commission in 1979) defined the poverty line as 'per capita consumption expenditure level, which meets the average per capita daily calorie requirement of 2400 kcal per capita per day in rural areas and 2100 kcal per capita per day in urban areas along with a minimum of non-food expenditure.' These poverty lines expressed in terms of per capita consumption expenditure conform

to a consumption basket, which satisfies the above calorie norm and meets a minimum of non-food requirements, such as clothing, shelter, transport, etc. Several debates are going on about the poverty lines and doubts have been raised on the indicators included and quality as well as source of data on the basis of which poverty estimates are derived. First of all, these estimates do not take into consideration expenses on health care and education that are incurred by the by the poor and which form a large portion of their expenditure. Secondly, the two sources of consumption expenditure data in India: the NSSO surveys and National Accounts Statistics (NAS) are problematic. There are serious differences between the two sets of poverty estimates (stemming from differences in measured consumption expenditures) and have created serious problems for planning for development in India, particularly when poverty is used as a parameter in the planning exercises.[5] Thus, there is a need to consider all these factors to have a real estimate of poverty in India and accordingly frame policies for the poor.

In urban areas, there is inequitable distribution of resources and services between the rich and the poor. This is reflected in poor access to basic services amongst the urban poor as compared to the average urban figures. According to NFHS-3, only 18.5 % of the urban poor have access to piped water supply at home as compared to 62.2 % urban non-poor population. Only 47.2 % of urban poor use flush or pit toilets as compared to 95.9 % amongst the urban non-poor. Lack of access to these basic facilities makes the urban poor vulnerable to several diseases.[6] Millennium Development Goal 7 (Target 11) aims to significantly improve the lives of at least 100 million slum dwellers worldwide by the year 2020. Even this very conservative target seems a tall order unless this large underserved section of population is adequately reached through public health services.[7]

1.3. Health Status of the Urban Poor

The health of the urban poor has been neglected since decades. Living in densely populated areas, lack of basic amenities, unemployment, poor nutrition, migration makes them vulnerable to several health problems. Weak and inadequate urban health care delivery system restricts the access to health care amongst the urban poor. Due to the limited access to the public health services, the urban poor do not have any other option but to depend on private providers whose charges are exorbitantly high and push the poor further into poverty.

The above situation is reflected in the poor health indicators. As per the re-analysis of the NFHS-3 data, Under 5 Mortality Rate (U5MR) among the urban poor is at 72.7,

significantly higher than the urban average of 51.9. About 47.1 % of urban poor children under-three years are underweight as compared to the urban average of 32.8 % and 45 % among rural population. Among the urban poor, 71.4 % of the children are anaemic as against the urban average of 62.9 %. Among the urban poor children 60 % miss complete immunization as compared to the urban average of 42 %. Only 18.5 % of urban poor households have access to piped water supply at home as compared to the urban average of 50 %. Among the urban poor, 46.8 % women have received no education as compared to 19.3 % in urban average statistics. Among the urban poor only 44 % of deliveries are institutional as compared to the urban average of 67.5 %. [2]

1.4. Urbanization and Health Status of Urban Poor in Gujarat

The state of Gujarat has a total population of 50 million as per 2001 census with 26.3 million being males and 24.2 million being females. It is one of the highly urbanized states in India with 37.36 % of the total population living in urban areas according to the 2001 census. In cities/towns reporting slum population in the state, nearly 15 % are slum dwellers. [8] It is anticipated that by 2010, 40 % of Gujarat's population will be living in urban areas.

Gujarat has made progress in certain maternal and child health indicators. There is an upward trend in percentage of institutional deliveries, which have increased from 37 % during NFHS-1, 46 % during NFHS-2 and 55 % during NFHS-3. Infant mortality has reduced from 69 (NFHS-1) to 50 (NFHS-3). Maternal mortality in the state has also improved from 389 maternal deaths per 100,000 live births in 1981 to 172 in 2003. However, we are lagging far behind in reaching the MMR goal of 100 per 100,000 live births and IMR of 30 per 1000 live births by 2012 as planned under NRHM and NUHM. [8]

Gujarat's performance in certain other indicators has gone down, like children under 3 who were underweight increased from 45.1 % (NFHS-2) to 47.4 % (NFHS-3). [6] Percentage of children fully immunized reduced from 50 (NFHS-1), to 45.2 % as per NFHS-3. There are wide gaps in certain maternal and child health indicators between the urban and rural Gujarat. The percentage of fully immunized children in urban areas has gone down from 61 in 1998-99 to 55 in 2005-06. Sample Registration System shows that though the urban IMR in 2004 was much better off at 38 as compared to 62 per 1000 live births in rural Gujarat, however, sex disaggregated data for urban areas in 2004 showed that IMR for girls was much higher at 48 than 30 for boys. In urban Gujarat, there were 18.5 % pregnant women who did not receive antenatal check up as per NFHS-3.

1.5. Urbanization and Health Status of Urban Poor in Vadodara City

Vadodara, the third largest city in the state of Gujarat, is one of the focal points of industrial growth in Western India. The city became a metropolis in 1991, along with eleven other major cities across the country, by crossing the one million-population mark. According to the 2001 census, Vadodara's population was 13.06 lakh and the population in 2005 has been estimated at around 14.69 lakhs. The population projection for 2011 is estimated around 17.54 lakhs and is based on the hypothesis that the city would grow at a constant rate due to the increasing urbanisation in the state. A survey in 1982 (ORG 1982) revealed that there were 255 slum locations in the city with a slum population of 0.95 lakhs, which had recorded a growth rate of 90 % from 1972 to 1982. In 2001, approximately 20 % (2.57 lakhs) of Vadodara's population lived in 336 slums. As far as the services are concerned, 88 % of the slum dwellers have access to water supply but only 46 % of them have access to drainage systems.[9]

A comparison between three multi-indicator cluster surveys (MICS) conducted by the Department of Preventive and Social Medicine, Medical College, Vadodara in 1998, 2001 and 2006 respectively, in the slums of Vadodara city, revealed a decline in the percentage of children fully immunized by the age of one year from 72 % in 1998 to 67 % in 2001 and 70.8 % in 2006. Vitamin A coverage also reduced from 50 % in 1998 to 34 % in 2001 and 36.7 % in 2006. However, breast-feeding practices showed a positive change with nearly 74 % children being breast-fed within one hour of delivery in 2006 as compared to 42 % in 2001 and 27 % in 1998. Percentage of pregnant women who had received ANC services increased from 86 % in 1998 to 89.5 % in 2006.

CHAPTER 2

Policy Environment for Reproductive and Child Health, Basic Services and Infrastructure Development in India

2.1. Reproductive and Child Health Policies

India's family planning programme has changed in its policy, approach and implementation drastically since its inception in 1951. The International Conference on Population and Development (ICPD, Cairo, 1994) marked a radical shift in thinking and action around population and development issues. Family Planning lost its pre-eminent place in service delivery to the concept of comprehensive reproductive health services across the life cycle. The result was the launching of the Reproductive and Child Health (RCH-1) programme in 1995 which expanded the services to include reproductive health of women, men and adolescents and included infant mortality as an important indicator.[10] The implementation of the first phase of Reproductive and Child Health (RCH-1) project showed the advantage of having an integrated approach in addressing health needs. However, there were limitations, as the programme did not yield the envisaged results.

Based on the lessons learnt from RCH-1, the second phase of RCH was launched after several decentralized and participatory deliberations with various partners. The goal of RCH-2 was mainly to improve the quality of life of people of India through Reproductive and Child Health and stabilization of population.

2.2. The National Population Policy (NPP 2000)

The NPP 2000 was announced in March 2000. It is the articulation of India's commitment to the ICPD agenda, and forms the blueprint for population and development related programmes in the country. The overriding concern of the National Population Policy is economic and social development and human well being. (Department of Health and Family Welfare, 2000). A cross cutting issue is the provision of quality services and supplies, information and counselling, besides arrangement of a basket of choices of contraceptives, in order to enable people make informed choices and enable them to access quality health care services. The immediate objective is to address the unmet needs for contraception, health care infrastructure, and health personnel and to provide integrated service delivery of basic reproductive and child health care.

2.3. National Rural Health Mission (2005-2012)

In 2005, the Government of India launched the National Rural Health Mission (NRHM) with the goal of "to improve the availability of and access to quality health care, especially for those residing in rural areas, the poor, women, and children." Its main focus has been to improve the quantity and quality of health infrastructure and building a cadre of community based health activists known as "ASHA" who would become a link between the government health system and the community. Currently this policy is being implemented in 18 states of India having poor health indicators and weak health infrastructure facilities and also includes small urban towns as well.

However, there was a need for a comprehensive health programme focusing on urban health issues. Thus, on the lines of the NRHM, government plans to launch the National Urban Health Mission.

2.4. National Urban Health Mission (NUHM 2008-2012)

In order to effectively address the health concerns of the urban poor population, the Ministry proposes to launch a National Urban Health Mission (NUHM). Although, the Mission was supposed to be for the remaining period of 11th Five Year Plan (2008-2012) it is still in the draft stage. The NUHM aims to address the health concerns of the urban poor through facilitating equitable access to available health facilities, by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of the urban poor. The existing gaps are planned to be filled through partnership with non government providers. This will be done in a manner to ensure well identified facilities are set up for each segment of target population which can be accessed as a matter of right. [2]

The core strategies planned under NUHM are as follows:

- Improving the efficiency of public health system in the cities by strengthening, revamping and rationalizing urban primary health structure.
- Partnership with non government providers for filling up of the health delivery gaps.
- Promotion of access to improved health care at household level through community based groups: Mahila Arogya Samittees.
- Strengthening public health through preventive and promotive action.
- Increased access to health care through risk pooling and community health insurance models.

- IT enabled services (ITES) and e-governance for improving access improved surveillance and monitoring.
- Capacity building of stakeholders.
- Prioritizing the most vulnerable amongst the poor.
- Ensuring quality health care services.

The NUHM would strive to put in place a sustainable urban health delivery system for addressing the health concerns of the urban poor. Since NUHM would complement the efforts of NRHM, the expected health outcomes of the NRHM would also be applicable for NUHM. The NUHM would therefore be expected to achieve the following targets (besides others) in urban areas:

- IMR reduced to 30/1000 live births by 2012.
- Maternal Mortality reduced to 100/100,000 live births by 2012.
- TFR reduced to 2.1 by 2012.

2.5. Jawaharlal Nehru National Urban Renewal Mission (JNNURM)

The Jawaharlal Nehru National Urban Renewal Mission (JNNURM) recognizes that a general lack of accountability of Municipal Corporations (MC) and other government agencies in the quality of service delivery is hampering economic growth and increased prosperity of urban citizens. In today's rapidly globalising economy, Indian municipalities, especially the 63 strategically important ones now targeted by the JNNURM, ought to facilitate their current and future local businesses to thrive. In addition to facilitating economic growth, municipalities should endeavour to meet the challenges set by the Government of India (GoI) in reducing poverty, by improving the livelihood of all its citizens.

JNNURM goal is to create economically productive, efficient, equitable and responsive cities.[9]

The main components of JNNURM are:

(i) Urban Infrastructure and Governance (UIG) for projects related to water supply and sanitation, sewerage, solid waste management, road network, urban transport and redevelopment of old city areas and

(ii) Basic Services for the Urban Poor (BSUP) for integrated development of slums through projects for providing shelter, basic services and other related civic amenities to the urban poor.

The NUHM and JNNURM give an opportunity to effectively address the reproductive and child health needs of urban poor.

2.6. SAHAJ's Analysis of the Policies

The positive features of the JNNURM are: the 40 % funds that have been demarcated for Basic Services for the Urban Poor and, the institutionalised mechanisms for both participation of the beneficiaries and transparency. However, in Vadodara the participation mechanisms are on paper, the urban poor communities' representation has not been sought nor have proactive disclosures of expenditures and progress on implementation been made.

There are strong conceptual links between the JNNURM and the NUHM. The BSUP are, in essence, the determinants of health - sanitation, water, drainage etc. The NUHM complements with the component of health care services. While the NUHM analysis of the health situation for the poor urban, cannot be faulted with, the solutions proposed are not congruent with the analysis. The document is not convincing about how the increasingly invisibilised urban poor, will be identified and their health needs addressed. How will daily migrant wage labourers be reached out to? Those who have no rights to residence (those living in unauthorized slums, pavement dwellers, and such like) have a lot of difficulty accessing schemes and programme meant for Below Poverty Line population – it is not clear how these difficulties will be addressed.

NUHM states that the solution to 'where no government health facilities exist' will be empanelment of private doctors/hospitals. This is problematic because the existing pattern of empanelment in the Chiranjeevi Scheme, has not worked in urban areas – we can say this confidently about Vadodara, at least. Why does the government not commit to investing in public health facilities at the primary and secondary level in urban areas?

The NUHM proposes a health insurance scheme for the urban poor. We can imagine what a nightmare it will be for poor, disenfranchised urban poor to get their claims- the costs (both financial and social) of getting the benefits of the existing Janani Suraksha Yojana are greater than the amount of money the women finally get in their hands. Instead, we propose universal access to free services at least for maternal and child health, and a social health insurance programme, as opposed to one run by commercial health insurance companies.

This then is the context within which SAHAJ-Shishu Milap locates its work in Vadodara city. The next chapter gives an overview of SAHAJ's work amongst the urban poor.

CHAPTER 3

Overview of SAHAJ-Shishu Milap

SAHAJ, Society for Health Alternatives was founded in 1984, with an idea of providing a supportive and facilitative atmosphere to persons interested in doing original work in the area of health and development. The common strand for all work of SAHAJ has been a conscious focus on marginalized and deprived communities, with an attempt to make a practical difference to peoples' lives and social processes.

SAHAJ's vision is 'A society where there is social justice, peace and equal opportunity for all.'

Mission

- To strive for health of poor communities-health defined in a broad sense to encompass the social, spiritual, economic and political.
- To strive for the practical relevance to the poor in all the work undertaken.
- To be innovative and creative and try and break new ground in work undertaken.

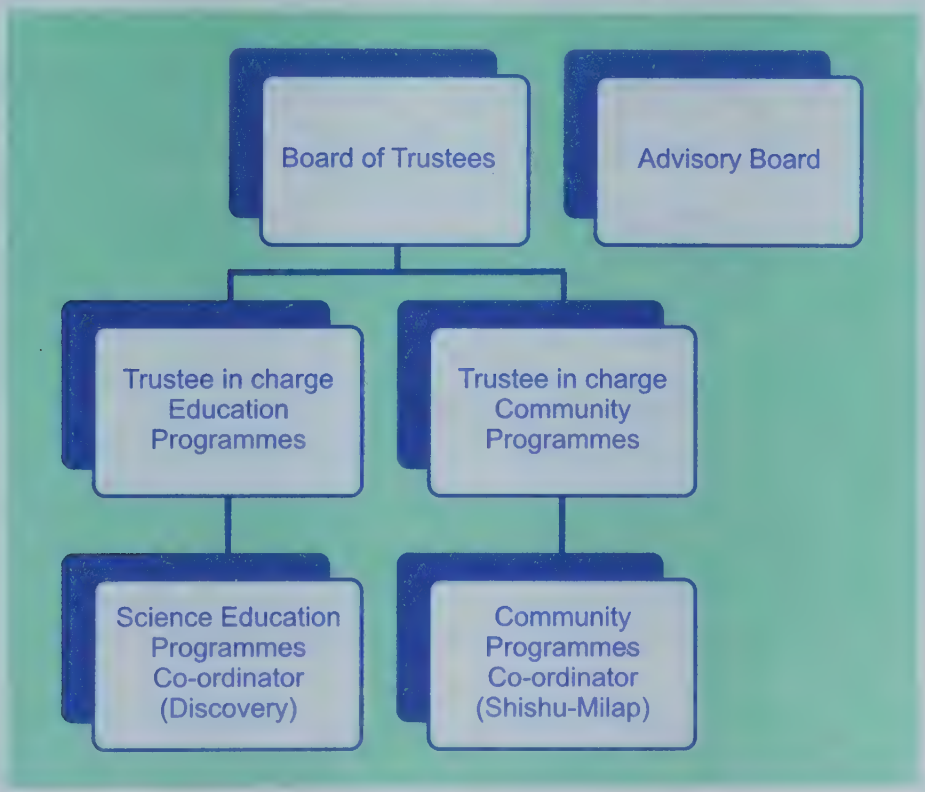


Figure 1. Organization Structure of SAHAJ

SAHAJ's work is divided in two arms – Community Programmes and Education Programmes which are implemented under the mentorship and guidance of one trustee

for each of the programmes. The Community Programme Co-ordinator is in charge of the implementation of these programmes in the community along other team members. As this report focuses on the Community Programmes, we have described the organizational chart of this programme in detail in the below diagram.

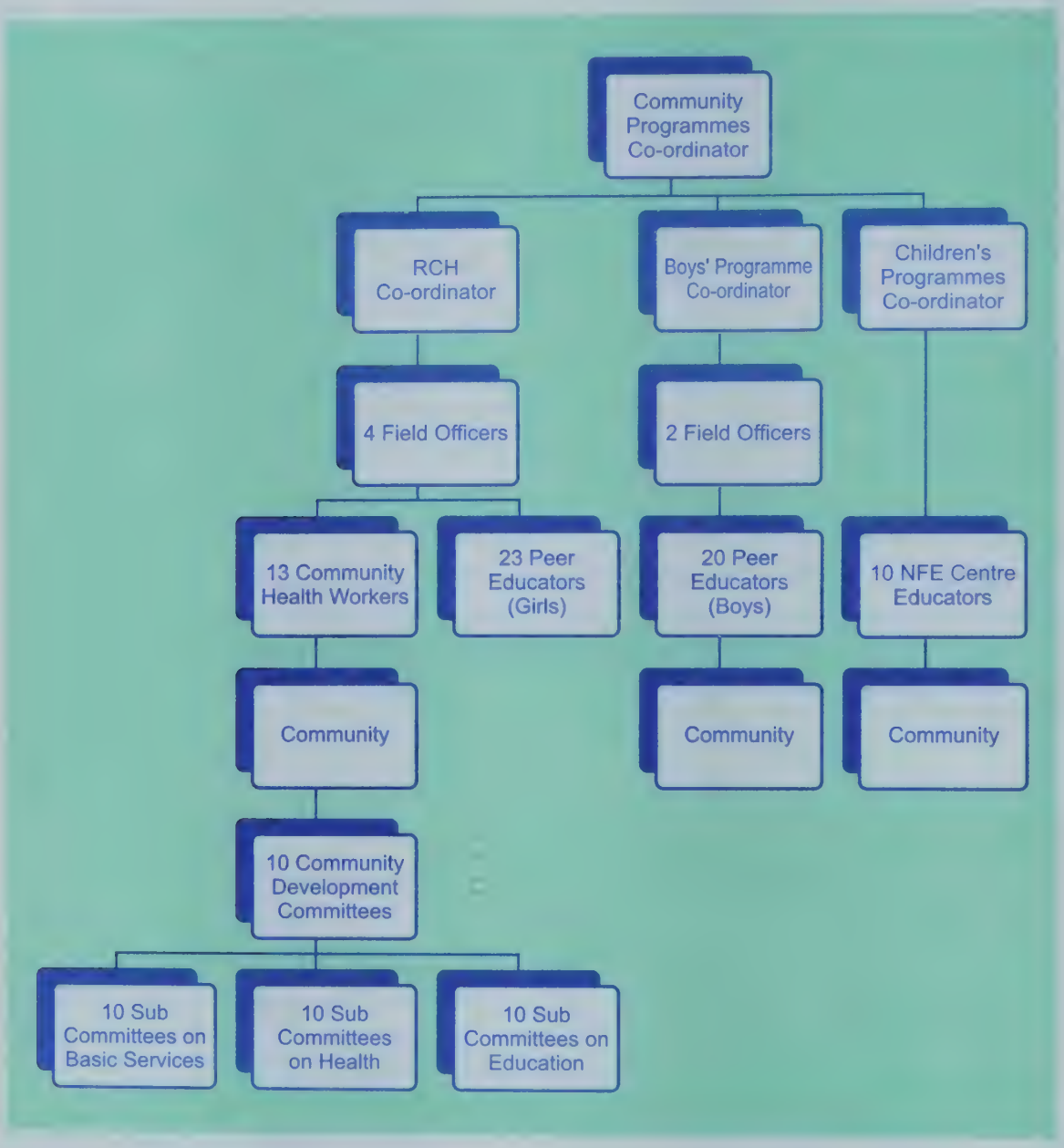


Figure 2. Community Programmes Organization Structure

The organization structure above depicts the Community Programmes component of SAHAJ. The entire team consisting of one Boys' Programme Co-ordinator, one Children's Programme Co-ordinator, four field officers for RCH and adolescent girls programme, two field officers for adolescent boys programme, forty three peer educators (twenty three girls and twenty boys), ten NFE educators and thirteen health workers and ten Community Development Committees as well as sub committees

on health, education and basic services, operates under the guidance of the Community Programmes cum RCH Co-ordinator.

The Community Programme mainly has four major activities being implemented in 16 bastis of Vadodara city.

3.1. Children's Programme

The main objectives of the children's programme are: to work towards quality education and to enhance self-esteem and team spirit amongst children. SAHAJ-SM runs Non-Formal Education centres in 10 bastis through a cadre of non-formal educators living in these bastis. Many children coming to SAHAJ-SM's centres had dropped out from school because of financial problems, poor quality of education imparted in municipal schools (where most of these basti children study) and lack of interest amongst parents in their children's education. These children are being re-enrolled in schools and children who faced financial problems are being supported through scholarship programmes. For improving the quality of education, NFE centres have made innovative worksheets and NFE educators have been given special training on complex topics resulting in improved performance of children in the centres as well as schools.

In addition, Bal Samitis or Children's Committees have been formed, with three to four representatives from each NFE centre. Bal Samiti meetings are convened once in two months to discuss issues related to children in their bastis and also to plan activities to be carried out with their peers like organizing sports events, picnics and exposure trips etc.

3.2. Adolescent Development

An action research project on adolescent girls and boys was conducted from 2004-07 amongst almost 1000 marginalized girls and boys living in 15 slum communities of Vadodara city. The project aimed at making a qualitative difference in the lives of adolescent girls in terms of their educational status, life skills and livelihood potential. In order to achieve this aim, following activities were conducted:

a. Adolescent Girls' Programme

- To address the specific needs of the girls related to the economic situation and educational status, the project reached out to 542 girls in the age group of 11 to 20 years. These girls got exposure to vocational training avenues by visits to institutions providing such training in Vadodara. Following the

exposure visits, the girls listed their interest areas for receiving training like embroidery, sewing, mehendi, earring making, bag making, crochet work, nursing etc. These skills were imparted to 542 girls and many girls have made it their full time vocation and are able to contribute towards their family income.

- Many girls had expressed a desire for basic literacy skills as many of them had either dropped out of school or had never been to school earlier. Thus reading and writing skill training was imparted to them through the non-formal education (NFE) classes which run in each basti. The NFE modules included maths, language and general knowledge.
- These adolescent girls were given opportunities and a platform through SAHAJ-SM to increase their self-esteem and self-confidence through various activities like workshops on gender and related issues, group discussions, sports events, celebration of festivals, annual days etc. Through these activities, hidden talents of girls were brought out and some bright ones who showed leadership were further trained to become peer educators in each basti. These peer educators conducted sessions and activities based on themes decided. From amongst the peer educators, a small editorial team runs a newsletter for adolescents called 'Yuva Sarjan Patrika'.
- Health and hygiene promotion activities were conducted amongst the adolescents like health camps, iron supplementation for anaemic girls and facilitating treatment for girls suffering from illnesses like tuberculosis, skin diseases, gynaecological problems, dental problems etc.

b. Adolescent Boys' Programme

SAHAJ-SM also works closely with adolescent boys in the age group of 13-21 years in 12 slums of Vadodara. The programme aims to promote gender sensitivity and responsible citizenship among them. So far, the programme has reached out to 350 boys through the following activities:

- Educational activities in small groups are conducted with school going boys like tuitions and supportive coaching. Activities like residential workshops, celebration of various events, organizing rallies etc. are conducted with older group of youth who may be school dropouts or employed youth.
- Peer educators have been appointed in each basti to organize other adolescent boys in the community and involve them in the development of their area as well as solving issues of non-functioning basic amenities, issues related to basti demolition, collecting necessary civic documents etc.

- Gender sensitization sessions have been conducted with adolescent boys in schools and bastis. These workshops have resulted in greater gender sensitivity amongst boys which is reflected in their behaviour and attitude towards women.
- Vocational training programmes have been conducted amongst the adolescent boys like computer courses, training in marketing, communication, writing and interview giving skills. Equipped with these skills, young boys have become more confident and have been successful in getting gainful employment and support their families economically.

3.3. Community Development

Community development (CD) has been the common thread which links all programmes conducted by SAHAJ-SM. While working with the community, SAHAJ adopts the principle of 'helping people help themselves'. A major component of CD is empowering the community through capacity building and formation of Community Development Committees (CDCs) in each basti. These committees address their local issues and advocate for their rights. Issues taken up by these committees focus on access to basic amenities like sanitation and hygiene, health services; obtaining certain civic documents like BPL cards, ration cards; preventing slum demolition or relocation of people who lived in slums now demolished.

3.4. Maternal and Child Health:

The activities conducted under the Maternal and Child Health Programme are described in the following chapters.

SAHAJ-Shishu Milap's Approach towards implementing its programmes:

- *Awareness raising.*
- *Evidence based needs assessment through Participatory Action Research.*
- *Formulation of need based programmes through participation of local people right from programme planning, to implementation and evaluation.*
- *Ensuring sustainability.*
- *Capacity building of local community leaders-as health workers, peer educators, children's committee members.*
- *Formation of basti level health, education and development committees.*
- *Evidence based policy advocacy.*

CHAPTER 4

Programme on Evidence Based Advocacy for Maternal and Child Health

4.1. Background

During group discussions on their bodies and health, and the pre-marriage counselling sessions, the adolescent girls showed keen interest in the topics and their mothers too started demanding health education. SAHAJ's experience of running a community development programme in the bastis showed that many women preferred to deliver their babies at home, even without trained attendants and women preferred to go to private providers for their reproductive health problems.

SAHAJ was also part of the recently initiated Coalition for Maternal Neonatal Health and Safe Abortion. The Coalition was planning small advocacy projects through its members. Given the background described above, SAHAJ-Shishu Milap decided to develop a proposal for Evidence Based Advocacy for Maternal and Child Health Programme and launched the programme in March 2006.

The recently launched JNNURM (2005) gave an opportunity to proactively intervene in capacity building of representatives to analyse the City Development Plan and examine public health determinants of health and basic services for the urban poor.

4.2. Programme Objectives

- To determine the maternal and children's health status in selected bastis of Vadodara city.
- To examine the quality of health services being used by urban poor for the above purposes and ascertain the approximate cost incurred in using these services.
- To increase communities' awareness on health issues and the government health services that they are entitled to.
- To identify and train a community health worker in each basti to provide basic health education, primary services for common illnesses and link the community with the public health delivery system in the city.
- To use data for advocacy at the city as well as the state levels in order to strengthen the related public health programmes and schemes and improve the quality and accessibility.

This chapter describes the activities conducted by SAHAJ to achieve the above mentioned objectives.

4.3. Methodology

- Participatory Action Research (PAR): Rather than the traditional approaches of doing surveys to identify needs, PAR provides for the involvement of people themselves in investigating their problems and issues. Thus PAR is not just about 'research', it is also a process of learning and taking action by the communities to address the issues identified by them during PAR. By involving the communities right from the beginning, PAR also involves advocacy from the beginning as it acts as an empowering process for the people to raise their concerns themselves.
- Advocacy: On the basis of the evidence collected, advocacy was done not only with the policy makers, but also with key actors at various levels: health service providers within the public and private sectors; members of the local government at the ward and corporation levels; civil society organizations working on similar issues; academicians and researchers; media; and at community level with individuals, families and other social groups. Mobilization and involvement of such diverse groups of people facilitates not only the formulation of appropriate policies and programmes but also their effective implementation and regular monitoring.
- Community based programme: This involves identifying and training a health worker in each of the 16 bastis. These community health workers (CHWs) are trained on various health issues with special focus on maternal and child health. They become a link between the community and the public health system and also create awareness on preventive aspects, use of public health services and people's right to access quality and affordable health care.

4.4. Programme Implementation

Objective 1: To determine the maternal and children's health status in selected slums of Vadodara city

Health needs assessment is a systematic method of identifying unmet health and health care needs of a population and making changes to meet these unmet needs. Health needs assessment is used to improve health and other service planning, priority setting, and policy development.[11]

In order to achieve the above objective, two baseline studies were conducted by the team of SAHAJ-SM in 16 different slum areas of Vadodara city to determine the status of maternal and child health in these slums. The first baseline study was conducted in July 2006 for 10 bastis of Vadodara city where SAHAJ had already been working for five

years on the issues of rights of children and young people. The second baseline study was conducted in July 2007 for 6 bastis where SAHAJ was working since one year only.

Main findings of the baseline studies

1. The average age for first marriage for women was 16-18 years.
2. The average age at first pregnancy amongst women is 19 years.
3. Only 75 % of childbirths were registered whereas only 13 % of the death of children was registered.
4. In 77.4 % pregnancies, women received antenatal check up. It is alarming that even in a city like Vadodara; more than 20 % pregnant women did not receive any antenatal check up.
5. It is found that most of the women have no knowledge about why the diagnostic tests like blood and urine tests were conducted during antenatal checkups.
6. Both the baseline surveys showed that the first PNC visits in most cases was received within 7 days (62.7 % and 59.5 % respectively). Notably, none of the respondents reported a post natal check up done on the same day of delivery.
7. Only 45 % of the children were found to be fully vaccinated while as many as 40 % of them were partially vaccinated as per first baseline whereas only 60.5 % children were fully vaccinated and 30 % children were partially vaccinated according to the second baseline.
8. In Baseline 1, only 27 % of the children were exclusively breast fed up to 6 months and in Baseline 2 also only 28 % of children were exclusively breast fed up to 6 months.

Main findings vis-à-vis current status of main health indicators

SAHAJ has set up a monitoring and information system of basic maternal and child health indicators. The monthly progress reports submitted by community health workers are fed into the M&E system which generates data to show the progress made and areas which need further strengthening.

1. Place of Delivery

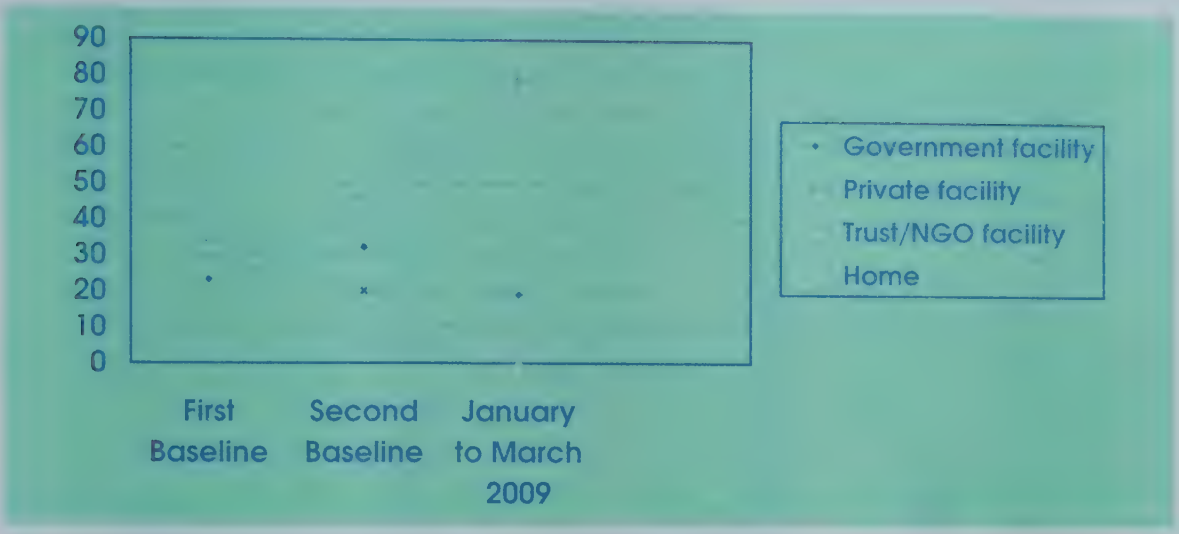


Chart 1. Place of Delivery

Data was collected about women's preference of providers for conducting deliveries in both the baselines. Chart 1 reveals that there is an increasing trend in women's preference towards private sector for deliveries. As compared to the two baseline figures, which shows 33 % and 46 % deliveries in private sector, this percentage has dramatically increased to 78.57 %. This finding is supported by the results from the latest round of morbidity data from National Sample Survey which suggest that there is an increasing trend in private health care use in the southernmost states of India in general and specifically in Tamil Nadu.[12]

This could indicate the apathy shown by the government in providing maternal health services to the urban poor despite of programmes like RCH-2 and NRHM. The increase in private sector deliveries is also a reflection of SAHAJ's effort to increase awareness of the Chiranjeevi Scheme. However, it is important to note that though the Chiranjeevi Scheme provides access to ANC and delivery services, it is promoting the private sector. The public expenditure is being diverted to the private health facilities through this scheme and is an area of concern. Rather than promoting the private sector, efforts of the government should be focused on strengthening the public health care delivery system.

The percentage of home deliveries has reduced from 35.7 % and 20.07 % in the first two baselines to 2.38 % in the last year. Efforts of SAHAJ in counselling women about safe deliveries and support for linking with Chiranjeevi and Janani Suraksha schemes have borne results in reducing home deliveries.

2. Type and Place of delivery

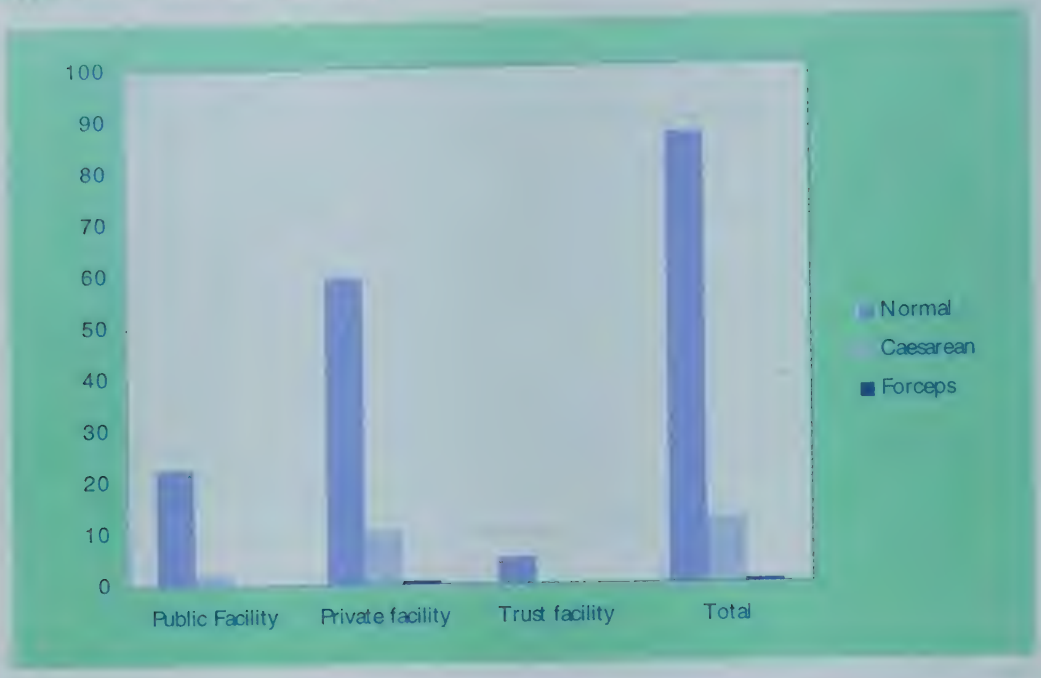


Chart 2. Type and Place of delivery

Chart 2 shows that out of total 160 deliveries recorded during April 2008 to March 2009, 86.87 % were normal deliveries, 12.5 % were Caesarean and 0.63 % were forceps deliveries. On disaggregating this data according the place of delivery, it was found that private facilities had the highest contribution towards caesarean deliveries which formed 10.62 % of total caesarean sections done as compared to 1.87 % in public facilities. This reflects the profit making motive of private providers resulting in supplier induced demand for caesareans and a higher out of pocket expenditure for the urban poor women.

All forceps deliveries, which is considered as an old technique, (not currently in practice as it causes damage to the brain of the new born), have been done in private clinics. This data reaffirms the need for setting up quality standards and monitoring mechanisms for private providers.

3. Sex of the children born

Table 1. Sex distribution of children born alive

Sex	First Baseline	Second Baseline	April 2008 to March 2009
	%	%	%
Male	45.7	49.71	48.17
Female	54.3	50.28	45.73
N. A.	-	0.01	6.10
Total	**100**	**100**	**100.00**

The above table depicts that the percentage of female children born as compared to male children has gone down from 54 % and 50.28 % in the two baselines to 45.73 % during the last year. This needs to be tackled sensitively through awareness meetings in the community about the social imbalance created due to sex determination and sex selection and about the PCPNDT Act. There is also a need to sensitize providers about this issue to prevent further imbalance in the sex ratio.

Objective 2: To examine the quality of health services being used by urban poor for maternal and child health and ascertain the approximate cost incurred in using these services

1. Quality of Health Care (QoHC)

SAHAJ also conducted a facility survey to assess the quality of care provided by health care providers in public and private (for profit and not for profit) sectors. For this facility survey, 11 hospitals, which were most commonly used by the women of SAHAJ's programme areas, were visited during July – August, 2008. The survey was conducted by a team of SAHAJ staff members, community health workers and health committee members.

The main findings of this survey are as follows

a. Tertiary Public Hospital:
   - Attitude of the birth attendants is negative.
   - With too many deliveries to handle in a day, the staff is over burdened with work.
   - Emphasis is on documentation rather than on treatment.
   - Lack of counselling services.
   - Patients and the family members are made to run around even to seek treatment for a simple condition.
   - Medicines are prescribed from outside.

b. Ward Dispensaries: Three ward dispensaries providing primary care were included in the facility survey. The main findings are:
   - Deliveries are not conducted here.
   - All the medicines for primary treatment are not available in these dispensaries.
   - Birth and death registration facilities are not available in Ward Dispensary No. 10 and 11.

- Availability of doctors for antenatal care is only once a week and for just two to three hours.
- Cases of early abortion are not handled at these dispensaries.

c. Private Health Facilities: Four private health facilities were included in this survey. It was found that:

- Many of the staff members are not qualified and not professionally trained.
- None of the hospitals have a Paediatrician.
- One facility under the Chiranjeevi Scheme does not have an emergency care unit for delivery cases and they refer at the eleventh hour to the government health facility (which has resulted in two neonatal deaths in November 2008).
- Unmarried women and girls below the age of 18 years are provided abortion services at the private facility hence there is a risk of unsafe abortions.

d. Private Health Facilities under Chiranjeevi Scheme: Three private providers who worked in the programme areas and were part of the Chiranjeevi Scheme were surveyed. While one private provider refused to respond, two providers consented to be part of the study.

These two hospitals were clean and provided good facilities like clean toilets and regular water supply. The buildings are also in good condition and there are separate examination rooms. Each patient is given enough time during the consultation. The patients also reported that the doctors' attitude and behaviour was good.

However, as mentioned above, one of the health facilities under the Chiranjeevi Scheme does not have an emergency care unit for delivery cases, last minute referrals to the government health facility resulted in two neonatal deaths in the month of November 2008.

Rekha's Story

Rekha Solanki. 30 years, visited the gynaecology department at SSG hospital right from the third month of her pregnancy. She went for regular monthly ANC checkups since March 2008 and took iron and calcium tablets regularly.

Payal (health worker trained by SAHAJ) accompanied her aunt Rekha during the 6th month. She noticed that the weighing machine was not set at zero and showed a difference of 2 kg. When she brought this to the notice of the intern doctor, the doctor got annoyed. Payal also observed the weighing procedure of another woman present. Again the weighing machine was not set at zero. The height of this woman was also taken in an inaccurate manner.

In the seventh month, Rekha had diarrhoea. During the ANC visit, she informed the intern doctor about this, who did not respond. Rekha then took some home remedies but these did not cure her. So she went back to the hospital. This time a senior medical officer was present and she prescribed a dose of 3 tablets, which did not stop the motions. Rekha went to a private doctor for treatment.

Rekha and her husband were asked to have their blood tests done. The doctor from SSG hospital told them that there were chances that Rekha would have to take a special injection at the time of delivery, which would cost between Rs 1500 to 3000. The intern doctor saw the report of the tests and said that everything was normal but when a senior doctor was shown the same report, she said that Rekha would have to take the injection at the time of delivery.

Rekha was asked to go back the following week for a routine check-up. The intern doctor told her that she still had one and a half month left for delivery. But according to Payal's calculation (taught during the SAHAJ training), Rekha had completed nine months of pregnancy on 16/8/08. Payal insisted on talking to the senior doctor. With difficulty she was permitted to accompany the patient to the consulting room. After examining Rekha, the senior doctor told her junior, "This woman is due for delivery. How did you calculate the EDD which showed one and a half months left for delivery? If you cannot calculate the EDD, ask the seniors". She immediately sent Rekha to the obstetric ward. According to Payal and the senior doctor Rekha had completed nine months and three days of pregnancy.

Rekha was admitted at 11.30 am on 18/8/08. She was left unattended for the whole day. The rush in the delivery ward was so much that 4 - 5 doctors could not pay individual attention to all the admitted women.

Seeing Rekha's condition, her relatives shifted her to a private hospital. A sonography was done by the private doctor who informed them that the amniotic fluid had reduced from 8 to 5 (the normal range is 8-12) this may be due to the loose motions she had during the previous month. The delivery was predicted to be induced and that they had to be ready for a caesarean delivery if necessary. She asked Rekha to get admitted the next day.

She was given an injection through saline to start the delivery pains. Rekha delivered normally at the private clinic. The family comes from a low income group and had to borrow money to pay for the delivery.

The above case study shows that inspite of early registration and regular ANC, women like Rekha end up delivering in private hospitals due to poor quality of services in public facilities. This puts further strain on the pockets of the poor to pay for private health services.

2. Quality of Nutrition Services for Children and Women

SAHAJ also conducted a survey of the Aanganwadis (AW) to understand the type of services provided and their quality. Out of the thirteen bastis under the project, eight have a functioning AW. Majority of them are run by the corporation and a few by charitable trusts. A small study was undertaken in five AWs after coordination with supervisors of the ICDS department. Perceptions of beneficiaries availing services from these AW's were also elicited. One AW, from each cluster of bastis that the project works in, was selected for this study.

Findings

1) The study showed that out of five AWs, three of them did not conduct medical check-ups of children, two did not have vaccination services and another two did not provide health education to parents and pregnant women and lactating mothers.

2) On interviewing Aanganwadi workers (AWW), it was found that they were unaware of the nutrition supplements that need to be given to normal children and malnourished children.

3) None of the AWWs mentioned about nutrition and iron supplementation to pregnant and lactating mothers as one of the services.

4) None of the AWWs mentioned about the discontinuation of supply of food by ICDS since January 2007.

5) According to parents, no health education is provided by AWWs

6) No written record of children's weights is given to the parents. All the records are kept at AW and in some areas, AWW provides information to parents.

7) None of the AW has a medical/first aid kit.

8) There is no weighing scale for elders, no IFA and calcium tablets for pregnant and lactating women, thus there are inadequate ANC services for them.

This shows the need for access to AW services in bastis where they are not available and the need to improve the quality of AW services as these have a direct impact on the nutritional status of children.

3. Cost of Health Care

Cost data is collected to know the actual amount spent by the families residing in Vadodara bastis, on delivery, treatment of gynaecological problems and abortion.

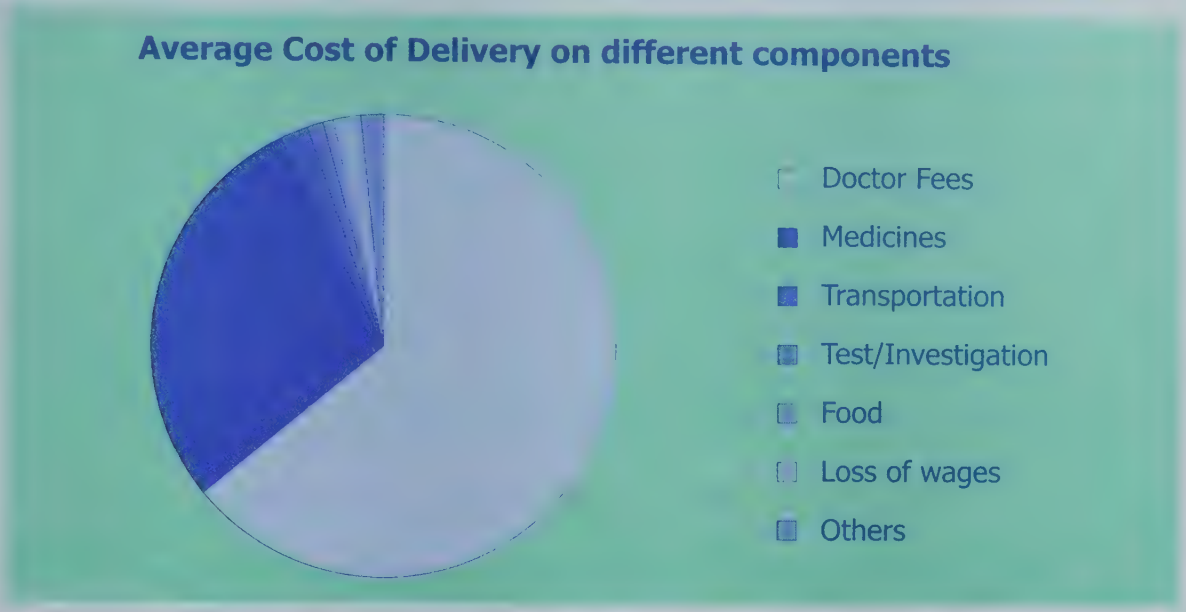


Chart 3. Average Cost of Deliveries on different components during April 2008 to March 2009

Data collected on the average cost of 160 deliveries that occurred during April 2008 to March 2009, on different components, is shown in Chart 2. It depicts that the highest burden of costs of delivery is contributed by cost of doctor's fees which forms 64 % of the total cost followed by cost of medicines which is 29 % of total cost of delivery. This may be attributed to the higher utilization of private health facilities for deliveries leading to higher costs. The direct average cost of delivery including doctor's fees, medicines, tests and investigations contribute to 94 % of the total cost.

According to the NCMH, Indian households spend 50 % of their total health expenditures on drugs and medicines. This is because the drug prices are rising in India. Only 76 drugs accounting for around one-fourth of the drug market are under price control. An examination of the price trends of 152 drugs (consisting of 360 formulations) reveals that antibiotics, anti-tuberculosis and anti-malarial drugs, and drugs for cardiac disorders, etc. registered price increases from 1 %-15 % per annum during 1976-2000.[20]

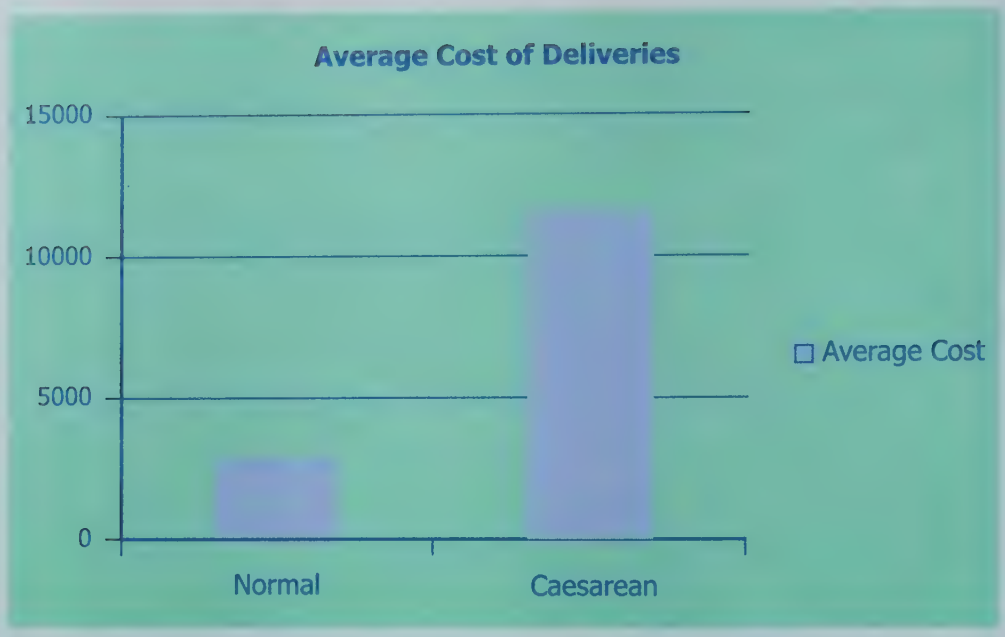


Chart 4. Average Cost of Different Types of Deliveries

Chart 4 shows the average cost of different type of deliveries. It shows that the average cost of caesarean delivery is Rs.11,507.57 and the average cost of normal delivery is Rs.2,877.45. This clearly shows that the average cost of caesarean delivery is 4 times higher than normal delivery.

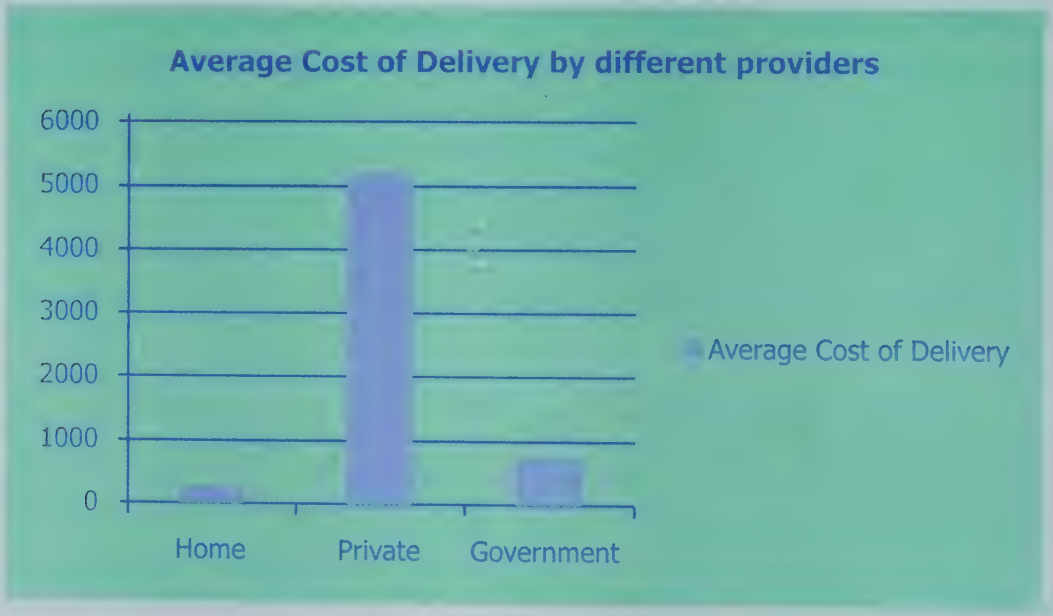


Chart 5. Average Cost of Delivery by different providers

Chart 5 shows that the average cost for delivery is the highest at private facility. Women have to incur on Rs.5200 on an average for delivering at a private facility as compared to Rs.770 at government facility. The cost of delivery at private facility is 6.75 times higher than that in a government facility. This data supports the study done in urban Tamil Nadu where the average cost burden was highest among patients who sought

care from private providers.[12] However, despite of the higher costs, women prefer to deliver at private facilities.

Table 2. Cost of Other Reproductive Health Problems

Health Problem	Public Facility		Private Facility		Trust Facility	
	Range of Cost (Rs.)	*Average Cost (Rs.)*	*Range of Cost (Rs.)*	*Average Cost (Rs.)*	*Range of Cost (Rs.)*	*Average Cost (Rs.)*
Abortion	450	450	654-2000	1192.80	0	0
Treatment for Gynaecological problems	0-500	100	40-4000	428.30	10	10

Seven cases of abortion were reported between October to December 2008 , of which five were done at private facilities, two at public facilities (one at ESI hospital so there were no costs to the patient). ESI services are available only for workers and their families in the formal sector which forms only 3 % of the Indian economy. The rest 97 % who work in the informal sector are not covered by any health insurance protection thus suggesting the need for social insurance schemes for the poor.

Most women were in the age group between 20-26 years and four out of seven abortions were induced. The average cost for abortion in public facility was Rs.450 and Rs.1192.80 in private facility which is almost 3 times more than the public facility.

30 cases of gynaecological problems reported during this period were irregular menstruation, RTIs/ STIs, excessive or little menstrual bleeding. Most women preferred to seek treatment from private providers. The lowest average cost of treatment for gynaecological problems was Rs.10 at a trust facility, followed by Rs.100 in public facility and Rs.428.30 in private facility. Again, this shows the wide difference between costs incurred in public and private facilities.

A study on 89 countries covering 89 % of the world's population reported that about 150 million people globally suffer financial catastrophe annually because of out-of-pocket payment (OOP) for health services (Xu et al., 2007). O'Donnell et al. (2005) estimated that in India, more than 37 million people go below the $1 per day poverty line and are further pushed into acute poverty because of out-of-pocket expenditure (OOPE). Out of pocket expenditure has been considered net of any reimbursement from insurance.[13] The findings from SAHAJ's data shows that the most urban poor women prefer to use private health facilities for delivery, abortions and treatment of RTI/STIs. The data also shows that majority of women had paid out of pocket for availing the above mentioned services as they do not have any social security protection thus pauperising them further.

4. Barriers in availing benefits of Chiranjeevi and Janani Suraksha Schemes

The Chiranjeevi Scheme and Janani Suraksha Yojana are meant for Below Poverty Line and SC/ST families. They were launched in Vadodara in August 2008. Pregnant women are registered under the schemes by the aanganwadi of the respective area. SAHAJ has been linking poor pregnant women with the scheme through awareness raising, helping with necessary documents and co-ordinating with private providers registered under the scheme. During August 2008 to March 2009, out of forty two women eligible for Janani Suraksha Yojana, only eight women received the benefits. And out of forty six pregnant women eligible to avail benefits of Chiranjeevi Scheme, twenty two actually received the benefits.

The main barriers that prevented women from availing the benefits of Chiranjeevi and Janani Suraksha schemes are from the supply side like:

a) Non-co-operation from AWWs for filling up necessary documents for registration under the scheme.

b) Women do not have BPL cards though they are eligible for them.

c) Women have APL cards though they are actually below poverty line.

d) Lack of proof of age; no ration card; election card.

e) Unfriendly or rude behaviour of AWWs, providers.

Demand side barriers:

a) Lack of information about the schemes.

b) Perception that quality of care provided is poor or not satisfactory.

Dr. Kothari who is registered under the Chiranjeevi Scheme and works closely with SAHAJ is of the opinion, *"The role of NGOs like SAHAJ-Shishu Milap is very important in spreading awareness about the Scheme, health education, motivating women for early registration and full ANC check-up, referring risky cases so that infant and maternal mortality can be reduced."*

A. Chiranjeevi Scheme

The Chiranjeevi Yojana is implemented by Government of Gujarat. It was launched in April 2005 to improve access to institutional delivery amongst poor women and at the same time provide financial protection to poor families in Gujarat. The scheme was piloted in five most vulnerable districts covering women below poverty line (BPL) and then expanded to the entire state including urban areas.

This initiative involves the private practitioners in service delivery. The scheme covers cash-less delivery at a private clinic empanelled by the government and also covers direct and indirect out-of-pocket costs such as travel and provides incentive to an accompanying person. The private empanelled providers are reimbursed on capitation payment basis at a fixed rate for each delivery carried out by them. The beneficiary gets one free ANC checkups and a free delivery at the Chiranjeevi hospital.

Who can be the beneficiary?

The woman has to belong to a BPL family. Age and parity are no hindrance in obtaining the benefit.

***Documents needed** – BPL ration card and residence proof.*

***Requirements** – Referral slip from the ward dispensaries or government hospitals to the Chiranjeevi hospital.*

B. Janani Suraksha Yojana

It is a centrally sponsored scheme, a revised version of the National Maternity Benefit Scheme, to reduce maternal and neonatal mortality rate. It assures the eligible women of ANC and PNC in government hospitals, treatment of complicated pregnancies and deliveries and also an assistance of Rs.600 in case of institutional deliveries and Rs.500 in case of home deliveries. The focus is on institutional deliveries.

Who can be the beneficiary?

The woman from a BPL/SC/ST family is eligible to get the benefits.

Requirements to obtain the services

1. Referral slips from the doctor in case of referred deliveries or complications during delivery or pregnancy. 2. Completely filled form with documents attached for receiving the monetary assistance. 3. Proof of residence – tax receipt, telephone bill, electricity bill, rent receipt etc.

Objective 3: To increase communities' awareness on health issues and the government health services that they are entitled to.

Health of a community is dependent on several factors like: biological, personal and family environment, social environment, physical environment and availability of public

services and public policy.[13] These factors are interlinked in a complex manner and many times one leads to another. Living in bastis increases the person's vulnerability of getting sick because of being poor as well as poor living conditions and non-availability of basic amenities. This affects the productivity of the person thus resulting in low income levels leading to further poverty.

The Government of India has developed national health programmes that strive, in principle, to be universal, comprehensive, and provided on the basis of need, not the ability to pay. Beginning with the Bhore Committee Report of 1946 and the Indian Constitution, the Indian state has affirmed a number of times its objective of enhancing the health of its citizens, reducing inequalities in health, and enhancing financial access to health care, particularly for the neediest. The Preamble to the Constitution of India, Articles 38 (2) and 41, stress the need to provide equitable access and assistance to the sick and the underserved, while Article 47 stresses on improving nutrition, the standard of living and public health.[14, 20]

In practice, however, there are several contradictions. There appears to be a lack of political will to ensure implementation of the health programmes based on the pillars of 'right the highest attainable standard of health care': accessibility, affordability, acceptability and quality of care. In addition, the poor are unaware of their right to health and health care which results in denial of timely and quality health services by the public health system.

SAHAJ has formed Community Development (CDCs) and Health Committees (CHCs) in each basti so as to provide the poor a platform to voice their concerns about their health and health services. Through a participatory process, SAHAJ team members formed these Committees in 14 bastis in 2007, comprising of 7-18 members (depending on the size of the basti). Initially, all development, health and education related issues were handled by these CDCs, but as time went by, as certain issues were

Capacity building of community development committees in SAHAJ office

solved by the CDCs, the community's demands increased. Thus, in November 2008, it was decided that a core committee now known as the Aarogya Committee be formed comprising of two to three members from each of the Community Development Committees.

The role of the Health Committee members is to be educators in the community and mediators between the government officials and the community. In order to take urgent decisions and immediate action on certain health issues, a smaller working committee has been formed comprising of 5 representatives (of which 4 are women) from the existing 30 member Health Committee.

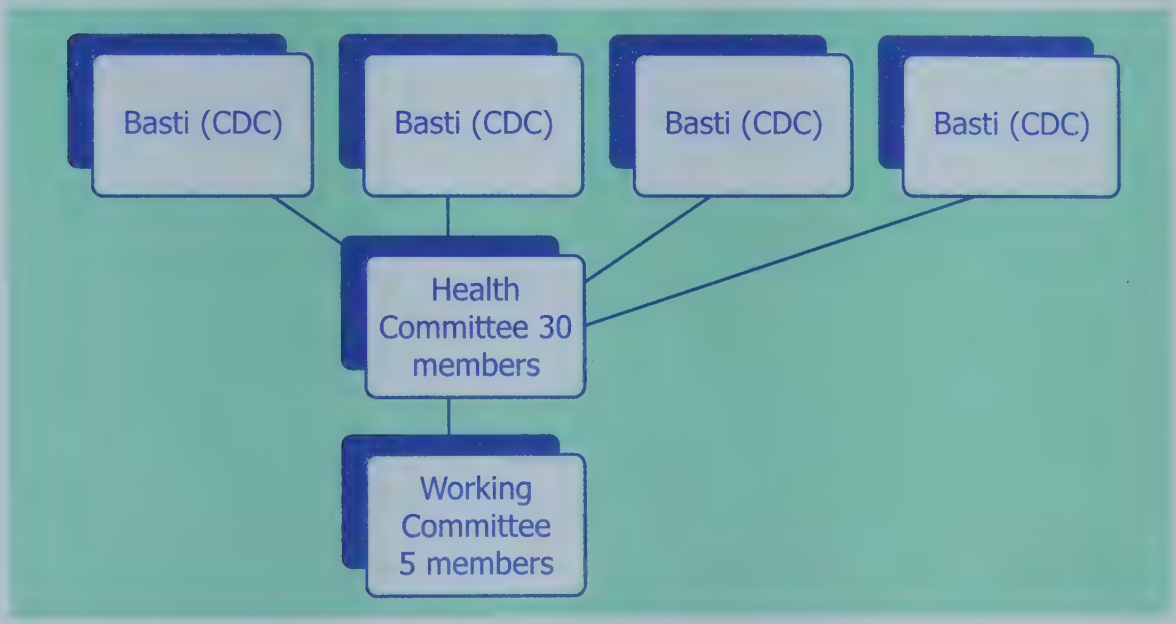


Figure 3. Structure of the People's Representatives

A process of awareness through dissemination of information was started with the CDCs and the CHCs using various mediums like area meetings, workshops on different topics related to the status of urban poor and services as well as schemes implemented by Vadodara Municipal Corporation (VMC) and the state government. This information included the following:

- Findings of the baseline studies conducted by SAHAJ focusing on poor health indicators in particular bastis.
- Health services provided by VMC's Health department
- Public health care delivery system and health services provided at primary, secondary and tertiary levels
- Maternal and child health
- Chiranjeevi and Janani Suraksha Yojana

Together We Can

VUDA (Vadodara Urban Development Authority) Slum Quarters built five years ago have 22 blocks with eight houses in each block. The colony houses 264 families (90% daily wagers). When they came to stay at the slum quarters, they were just given the houses without any basic services. They gradually got services like water and electricity but even now the colony does not have street lights. Every monsoon, the colony gets flooded with water, which enters the underground water tanks thus contaminating the water source. The electricity meters and motors for drawing water in the overhead tanks get submerged in rain water resulting in dangers of short circuit or electric shocks.

SAHAJ-SM started its work in this area in November 2007 and started organizing women and adolescents to work together for solving local issues. Their capacity building was undertaken through various programmes like health awareness, vocational training, non-formal education and community development. A committee of local residents was formed with 22 members (1 from each block) and a core committee from amongst them with 12 members (4 members each looking after community development, health and education related matters). They started with the issue of sanitation and garbage disposal of their area. When they approached the local municipal authorities about the problem, they discovered that as per the records of the municipal ward office, the residents of VUDA were non-existent! They were told 'We haven't heard of this area, it does not fall under our coverage area so we cannot provide any services.' The committee decided to tackle this problem by collecting a common fund from all the residents and hire a person who would keep their neighbourhood clean. In 2008, they spent Rs.1400 in two months, for paying the person hired and purchasing dustbins and brooms. The committee won the trust of the local residents by successfully maintaining cleanliness in their area and by being transparent about the funds collected spent and remaining balance. However, this did not continue for long - there were some residents who were not ready to contribute to the common pool of funds. Further education and awareness amongst the committee members - awareness sessions on rights of citizens to obtain basic services - made them decide that they would demand for their rights from the municipal corporation. The committee members held several meetings with the ward officials, finally being able to convince them for garbage collection and cleaning of the area regularly. Now the ward office has arranged for a weekly collection of garbage and cleanliness of the area.

The second issue taken up by the committee was that of aanganwadi for their children. As there is no aanganwadi in their area, the children have to go to another area. For reaching the other area, the children have to cross a road and there have been incidents where children and their mothers have been injured in road accidents.

The committee has also met their local corporators who were not aware of VUDA Slum Quarters' existence in their constituency.

Two meetings with the corporators have been fruitful. The committee has written an application regarding issues faced by them and the corporators are planning to conduct a meeting with the local residents soon.

The committee's future plans includes a list of tasks to be completed like blocked drainage, aanganwadi for their children, street lights, changing the electric meters and getting them fixed higher on the wall to prevent them getting submerged during monsoons. Along with the development of their area, the committee is also willing to help other communities by sharing their experiences of solving their problems through a local committee.

The committee members say that the training and exposure they received from SAHAJ has made them self-confident. Before being involved with SAHAJ, they were not able to speak out about their rights and approach any government officials. But now they demand for the services required. They are happy that after initial distrust and non-cooperation from some local residents, now they have earned a trusted position amongst their neighbours, due to the work they have been able to do.

This information was in turn disseminated in the community by the committee members, generating awareness and a demand for quality and timely health, nutrition and other basic services.

The Gujarat Public Health Act (draft) and NUHM mission document includes sections on (Chapter IV) monitoring of the public health care system by forming health committees at various levels from the community to the city. Powers and responsibilities will be given to these committees to ensure that the urban poor have access to adequate, timely and quality health services. These committees need to be formed under the JNNURM and NUHM. Thus SAHAJ's experience of forming, capacity building and strengthening of health committees in bastis of Vadodara can be helpful in up scaling these in other parts of the city. Secondly, the sustainability of the committees set up by SAHAJ will be ensured if they are recognized by the JNNURM and NUHM.

Objective 4: To identify and train Community Health Workers to provide basic health education, primary services for common illnesses and link the community with the public health delivery system in the city.

It was planned to build a cadre of community health workers in each basti so that they would become a link between the public health delivery system and the community. SAHAJ started identifying potential health workers from all the sixteen bastis during the programme's inception. Currently there are thirteen health workers, one in each basti (two bastis have been demolished and one basti does not have a health worker due to unavailability of a literate person). This team of health workers are provided supportive supervision by four field officers and an RCH Co-ordinator from SAHAJ.

This cadre of health workers were provided several types of training and opportunities for exposure.

A. Classroom training

The health workers were initially given one week training the following topics:

1. Reproductive Health

- Anatomy and physiology
- Female and male reproductive system and functions of each organ
- Menstruation and conception,
- Pregnancy – Antenatal care, post natal care, danger signs during pregnancy , during and after delivery
- Family planning
- Child health, nutrition, immunization
- Common diseases and its treatment

Training of Community Health Workers in SAHAJ office

2. **Child Health: A six day training was conducted for health workers and staff members of SAHAJ which included the following topics:**
   - Growth monitoring
   - Development stages till 3 years
   - Malnutrition
   - Vomiting
   - Diarrhoea
   - Cold and cough
   - Importance of immunization
   - Breast feeding

This training included the rights of the child with reference to each of the above topics and the responsibilities of mother, father, family members and health workers.

Endless Dreams

Sarju Rathod is a 20 year old health worker, who is bubbly, always smiling and full of enthusiasm. She lives in Rampura with her mother and grandmother who are 42 and 85 years old respectively. Her mother runs a small shop selling firewood and her grandmother used to rear buffaloes and goats but now she is too old to do any work. Sarju studied till 10th standard. She started going to the NFE classes run by SAHAJ-Shishu Milap since she was a kid. Then, after, becoming an adolescent, Sarju was trained to become a peer educator and conduct awareness sessions amongst other adolescent girls in her community. While attending meetings conducted for peer educators, she was selected to run a NFE centre in a nearby basti, Ramvadi. She successfully managed the NFE centre for two years, after which she was transferred to another basti, Santoshnagar where she managed the NFE centre for one year. Currently she is handling dual responsibilities of managing a NFE centre in Gadapura and working as a health worker in Rampura. She got interested in health activities of the organization when she observed some training sessions conducted for health workers. On her request, the health team co-ordinator trained her as a health worker. She has always been supported by her family members to follow her dreams and develop. She laughs while talking about her grandmother's comments about her constantly changing work and says, "Grandmother told me, why you are jumping from one work to anothe? Stick to one activity." "So I told her that I like this work and it gives me many opportunities to learn new things." She says that her mother and grandmother are very happy when people from the community come and praise her for her work.

Regarding the change in the health status of her community women and children, Sarju said that most people from her community belong to the Vaghri caste and their main occupation is making clay toys. Most of the women are busy raising their children and earning their livelihood and do not have time to think about their own and their children's health. Initially when she started working as a health worker, many women had more than 6-7 children and they delivered at home. They did not get their children immunized, nor did they send them to the Balwadi. But now, since the health related activities have started in the basti, institutional deliveries have increased, and women have starting adopting contraception for birth spacing. They also seek her advice if their children are ill.

She has umpteen dreams; one of them is to immigrate to United Kingdom to earn a better living for her mother and grandmother. Secondly, she wants to learn how to conduct a safe delivery. She says that once these dreams come true, she will think of other dreams.

B. Practical and on-the job training

After the basic training on reproductive and child health and common diseases, the health workers were given on the job training in conducting health education sessions in the basti. They were taught how to conduct home visits and counsel pregnant women and their family members maintain records of each child and woman and write weekly reports.

C. Exposure Visits

After the practical training in the community, the health workers were periodically taken for exposure visits to SSG Hospital, ICDS department, Department of Social Welfare and Social Defence so as to understand their functioning, services and schemes implemented, documents required to avail benefits of schemes, etc.

Health Committee meating with the Health Officials for new Anganwadis

D. Weekly reporting meetings and experience sharing

The health workers prepare weekly reports and present them in the reporting meetings held at the SAHAJ office once every week. These meetings give them an opportunity to share their experiences in the community and about the interventions that benefit the local residents or if they had specific problem they could not handle.

Along with reporting, the health workers also receive refresher training on topics they want more information on. These meetings also become a platform for the health workers to raise the issues faced by them in the community or from the health care providers and systemic problems. The field officers and RCH co-ordinator help them sort out these issues by co-ordinating with concerned government or ULB officials as well as community members. The weekly meetings are meant for monitoring progress against planned activities and changes that are required in the following week/month based on the needs raised during implementation.

Main Achievements of Health Workers

1. The health workers have been able to reach out to 15600 households by making individual home visits in 13 bastis.
2. They have arranged for registration of 173 pregnant women in government and private hospitals during the programme period and have referred over 100 pregnant women having complications during pregnancy.
3. Distribution of IFA tablets to approximately 200 pregnant and lactating women (completed course of 100 tablets each) and 75 other anaemic women.
4. Family planning
   - *Condoms- 75 new users and 53 old users*
   - *Oral pills – 10 new users and 8 old users*
   - *Motivated 15 women for IUD insertion*
5. Referred around 60 women having gynaecological problems who received full course of treatment.

CHAPTER 5

Evidence Based Advocacy

5.1. Evidence and data

Evidence and data are provided for a reason - usually (but not exclusively) to change and improve the quality of decision making. The essential database of evidence can only be determined by a dialogue between those who are using it and those generating it.[15]

Evidence on urban health indicators especially disaggregated data at slum level has been missing in the MIS generated by the government. Most data sets capture health information at national, state and city level. Secondly, whatever data is generated is collected by people working with the government; researchers and academic institutions do not involve the participation of local people about whom this data is being collected. As a result, the use of this evidence remains limited to government reports submitted to funding agencies, published in journals which have limited readers (mostly academicians and researchers). It does not reach the policy makers or the local communities and the language of this data is not simple for a lay person to understand.

This leads to a situation where new health policies and programmes are formulated on the basis of limited evidence from the ground thus making it ineffective in reducing the disease burden in urban areas. In addition, the data generated is not being disseminated amongst the urban poor in a manner that they can understand, thus leading to lack of awareness amongst them about the extent of health problems and lack of demand creation for better health programmes and policies.

In order to bridge the gap between the researchers and policy makers as well as people, SAHAJ has used the strategy of evidence based advocacy by generating data about the health condition of the urban poor through PAR. This methodology treats the urban poor as equal partners in generating data that is important to them and uses it for advocating for their health rights. In addition, it also demystifies complicated data sets into easy- to- understand information which the poor people can use for bringing changes in their health seeking behaviour as well as putting forward their demands for better health security.

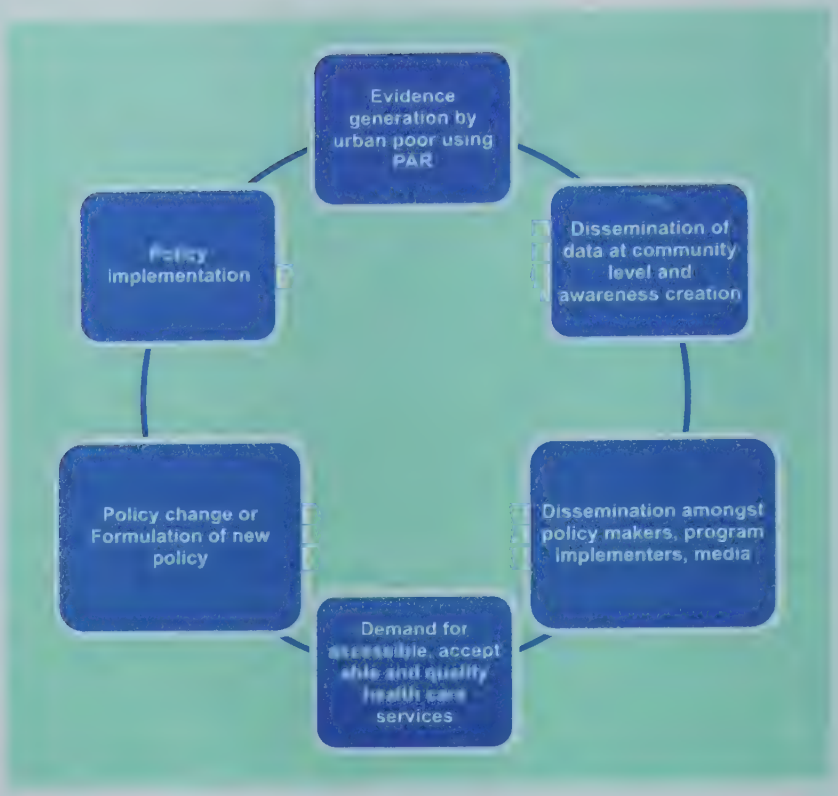


Figure 3. Conceptual Model of Cycle of Evidence Generation and Policy Change

5.2. Advocacy for Health and Health Care as a Human Right

Equal human rights for all human beings is not only a principle of international human rights, but a core principle of the Indian Constitution. The concern of the international community to protect human rights was reflected in the formulation of the UN Declaration of Universal Human Rights in 1948 and in the Indian Constitution through Articles 14 and 15. The right to health was articulated in the international arena through the International Covenant of Economic, Social and Cultural Rights, while the Indian Constitution included the Directive Principles to address the issue. The Indian Constitution is a progressive constitution, incorporating many features of the 'rights based approach' within its framework. Several health related policies and programmes formulated by Government of India reflect its conviction for protection of health as a human right of its citizens. Especially, while considering Reproductive and Child Health, we find rights based approach reflected in :[16]

- the law permitting abortion (something that women of many 'developed' countries are still struggling for),
- laws prohibiting sex pre-selection and female infanticide,
- provision of free contraceptive services and free abortion services,
- government programmes for safe motherhood and reproductive health,

(Including RTIs, STD, HIV/ AIDS),

- shelter homes/women's police cells/family counselling units/National Commission for Women, and
- laws prohibiting child marriage and immoral trafficking.

However, we still see these rights being violated by the state itself as well as society. The implementation of policies and programmes has several gaps that result in violation of reproductive rights. Thus there is a need for advocating for these rights using ground realities as evidence.

The minimum health requirements of every citizen that need to be advocated for are :[17]

Availability - public health care facilities must exist in sufficient quantity. At a minimum, this includes safe drinking water, adequate sanitation, hospitals and clinics, trained medical personnel receiving domestically competitive salaries, and essential drugs

Accessibility - health care must be physically and financially accessible. It must be provided to all without any discrimination. Information on how to obtain services must be freely available.

Acceptability - all health facilities must be respectful of medical ethics, and they must be culturally appropriate

Quality - health facilities, goods, and services must be scientifically and medically appropriate and of good quality. At a minimum, this requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe water and adequate nutrition (within the facility) and good interpersonal communication

Advocacy is an important component of the rights based approach. Policy or public advocacy is different from legal advocacy in the sense that it does not necessarily involve courts or the judicial system. However, it is closely concerned with the rights of the underprivileged or the marginalised. Public or policy advocacy involves the creation of public pressure for influencing policy formulation, programme implementation in the interest of the poor, underprivileged or the marginalised. Such advocacy efforts are usually directed towards those groups or individuals who are in decision making positions and could include policy makers, legislators, senior programme managers and so on. The advocacy initiatives can be taken by the affected groups themselves or by other members of civil society who are concerned.[16] Amongst others, media advocacy is an important strategy. It seeks to develop and shape news stories that build support for public policies and ultimately influence those who have the power to change or preserve laws, enact policies and fund interventions that can influence whole populations.[18]

5.3. Advocacy strategies adopted by SAHAJ

Based on the evidence collected through the baseline studies, facility survey, aanganwadi survey, reports of the health workers, reporting of basti level health and development committees, SAHAJ adopted the following advocacy strategies with a multi-pronged approach for advocating the right for health and health care for the urban poor.

Figure 4. Strategies adopted by SAHAJ for Evidence based Advocacy

1. Dissemination of evidence at community level and demand creation for adequate and quality health and nutrition services for women and children

Several awareness meetings were held with the Community Development Committees (CDC) and Community Health Committees (CHC) on findings of the baseline studies, aanganwadi survey, and cost analysis of deliveries. Each committee member took the responsibility of sharing these findings to all other residents of the community. These meetings resulted in creating demand for adequate supply of health and nutrition services for women and children in the communities. Committee members made presentations before the ICDS and health officials, wrote letters to the Commissioner of Health of Gujarat regarding unavailability of AW services in many bastis and asserted their right to health and health care through these efforts.

Basti level meetings by the Community Development Committees

2. Jan Samvads

Jan Samvad means 'People's Dialogues'. Two Jan Samvads were organized. In the first one, around 300 people participated. SAHAJ facilitated an interface between the government officials, public and private providers, elected representatives and people of the community. It aimed at boosting the efforts towards communitization of health services, and to bridge the gap between the government machinery and the CDCs and CHCs.

Jan Samvad with Health Care Providers

Issues raised during the Jan Samvads were:

- Unavailability of BPL cards, ration cards resulting in denial of health and other public services to the urban poor.
- Lack of AW services in communities.
- Poor access to health services for women and children.
- Poor access or lack of basic amenities - sanitation, water, electricity etc.
- Poor quality of maternal and health services provided by government health facilities.
- Cases of denial of health services by public and private providers.

In the second Jan Samvad, the Community Health Workers and the Health Committees apprised the elected representatives (the corporators) of their basti level problems. As reported elsewhere, joint action by the corporators and health committees is resulting in improvements.

Jan Samvad with Corporators

3. Workshops with lawyers, religious leaders, media persons, political leaders, students

SAHAJ and Aarogya Trust were part of a district level campaign to prevent Early Marriage and Early Pregnancy. Two district level workshops were organized on this issue with members of the community, lawyers, professors, labour commissioner, doctors, corporators, NGO representatives, religious leaders, media representatives of local TV channels and newspaper reporters.

Religious Leaders at the meeting on "Early Marriage and Early Pregnancy"

4. National, State and District Level Advocacy

a) SAHAJ has been part of an initiative to draft a Public Health Act for the state of Gujarat. Team members have put forth their viewpoints at several state level meetings.

b) In a meeting at Gender Resource Centre aimed to discuss action steps and indicators for implementation of the Health section of the Gender Equity Policy, Government of Gujarat, the issues raised by SAHAJ-SM were:

- Nutritional status of women and children in Gujarat has declined since NFHS-2. Government of Gujarat needs to take corrective action to stall this decline.
- Safe abortions do not figure anywhere in the MIS of the Health Department. The department needs to take steps to ensure that reporting of Safe Abortions does happen because unsafe abortions are a significant cause of maternal mortality and need to be paid attention to. Access to safe abortion services is an issue for women.

- Efforts need to be made by Government of Gujarat for improving the health of the urban poor women. It was suggested that the State Health Department set up coordination links with the Municipal Corporations/ Councils and integrate rural and urban health through the District Health Societies.

c) Baroda District JSA Meeting with the CDHO, Vadodara

Following a meeting of JSA Gujarat representatives with the Commissioner of Health and CDHOs, each CDHO was directed to convene a meeting with District JSA members. Baroda CDHO was the first one to convene this meeting. Representatives from four NGOs were present – DCT / DMF, Lifeline Trust, Lakshya Trust and SAHAJ.

Points of emphasis from the NGOs were:

- Civil Society representatives and the district officers should make Baroda a model district in which the concept of the District Health Society is implemented in an exemplary way. Increase civil society participation by becoming members of the District Health Society and other committees.
- Synergizing skills of all partners like research, training, community mobilization to achieve common long term goals in a spirit of partnership and mutual accountability
- Foster direct mutually respectful communication.

d) State level meeting on Human Development Index performance of Gujarat

Issues raised by SAHAJ-SM were:

- Placing the human development and health indicators in Gujarat within the framework of human rights to health. The state has to put in place a grievance redressal mechanism for health rights' violation, if it is serious about human development in the state.
- Adolescent girls should not be addressed only as future mothers. The Health Department is only concerned with delaying age at marriage of young girls. Girls have a right to be well nourished regardless of their productivity and reproductivity.
- Need for including sexual health needs of adolescent boys in Nirogi Balak scheme.
- Convergence of HIV/AIDS and RCH programmes at community level.

Networking and wider dissemination through Jan Swasthya Abhiyan (JSA)

At a state level meeting of JSA members with the Commissioner of Health Chief District Health Officers (CDHO) and Chief District Programme Officers (CDPO), SAHAJ representatives raised the issue of health services for the urban poor. Though infrastructure exists, system of ensuring health care is missing, when it comes to the urban poor. Inadequate health services at the primary heath care centres forces the poor to approach tertiary level health care centres. They have to spend money for travel, and bear the loss of wages besides paying for medicines. Thus their greater inclination towards availing health services from private health providers.

National level Advocacy

SAHAJ's trustee has been participating in several national fora to advocate for gender and rights issues in health. As a member of the RCH-2 Mid-Term Review, SAHAJ's representative highlighted that senior nurses are invisible in health policy formulation at the national and state levels. Other neglected issues are access to safe abortion services, health issues of the urban poor, regulation of the private sector, among others. SAHAJ along with SAMA and JSA also organized a national consultation on health of the urban poor to analyse the NUHM.

5.4. Impact of evidence based advocacy

Adopting a multi-pronged approach of advocacy has yielded some positive results:

- CDC members were given a list of BPL families of all slums covered under the programme. Now the community members who have been missed out

National meeting on 'Health Needs of the Urban Poor", New Delhi

of the BPL list can be identified and added during the next BPL survey.

- Problems related to basic amenities like blocked drainage lines, water contamination, garbage collection etc. are responded to and solved.
- Mobile health van reaching out to the interior parts of one community which is far flung.
- Pregnant women who are really poor and do not have BPL cards are provided referral letters by ward dispensaries so that they can avail the benefits of Chiranjeevi Scheme.
- Nutrition supplementation has started reaching the AWs.
- Good rapport is being established gradually between community and concerned health officials.
- Wide media coverage to issues raised (see Annexure 2 media clippings).
- Positive response from other stakeholders like lawyers, academicians, religious leaders, students in spreading awareness on prevention of early marriage and early pregnancy.

CHAPTER 6
Challenges and Lessons Learnt

During the implementation of the evidence based programme on maternal and child health, several challenges faced by the communities, came to the forefront.

6.1. Challenges

- Within the three years of the community health project, three bastis have been demolished without new houses being readied for the displaced families' resettlement. This has resulted in the poor being dispersed and scattered. This kind of invisibilisation of the urban poor is being increasingly recognized. In this context, how will the NUHM respond?
- Access to primary health care including maternal and child health services

  SAHAJ's work revealed that women do not have access to primary health services at the community level. Most of the basti residents rely on private providers for obtaining primary health services like treatment for common diseases like fever, common cold, skin diseases etc. Currently there are 16 municipal dispensaries in Vadodara, which means that every dispensary caters to a population of approximately 92000 (based on 14.69 lakh population of Vadodara 2005) as against the rural Gujarat which had 3.9 CHC/PHC per 100,000 population.[19] .

  In addition to lack of services for common ailments, women and children do not have access to health and nutrition services. As per the Aanganwadi survey done by SAHAJ in 2008, out of 16 bastis where SAHAJ works, 5 bastis do not have an Aanganwadi. As a result 721 children in the age group of 0-6 years do not receive immunization and nutrition services. In these 5 bastis, pregnant women and lactating mothers do not have access to IFA tablets, weight monitoring and nutrition supplementation.

  Pregnant women have to depend on the ward dispensaries for receiving ANC services which are quite far from their communities or they have to go to private providers or go the SSG hospital for certain ANC services not available, like sonography, blood test etc. For deliveries too, women either have to go to the tertiary government hospitals or private providers.

  Thirty years after the Alma Ata Declaration on Primary Health Care (1978), we are a far cry from the promise of universal access to primary health services,

including water and sanitation; food and nutrition; immunization against 6 major diseases; mother and child care (MCH)/Family Planning (FP); prevention and control of locally endemic diseases; treatment for common diseases and injuries; health education and provision of essential drugs.

- Costs of health care services

  Due to unavailability of public health services, most urban poor families depend on private providers where the cost of health services is very high as compared to public providers. Though the poor cannot afford the high costs of care, they pay out of pocket for most of the health services. In absence of any health insurance programmes for the urban poor, they incur heavy debts by borrowing from relatives, money lenders, pawn jewellery etc. thus pushing families further into deep poverty. The unpredictability of illness requiring substantial amounts of money at short notice is impoverishing an estimated 3.3 % of India's population every year. 10 % of the population rely on sale of their assets or on borrowings. [20]

  Though it is claimed by the government that public health services are provided free of cost, pregnant women have to pay for most services. Women who live far from the government hospitals have to pay even more for ANC, delivery and PNC services because of transportation and wages lost or resort to private providers for care. High cost of care mainly includes cost of medicines.

- Lack of mechanism for monitoring of the private sector: After analysing the cost data of deliveries, gynaecological problems, we have learnt that the range of fees charged by the private sector falls in a wide range. There are no guidelines for quality standards and system set up for monitoring the cost of health services provided by the private sector. Absence of such a mechanism makes the poor vulnerable to unscrupulous practices of private providers.

- Quality of health services: Quality of health services includes various dimensions like access, effectiveness, efficiency, acceptability, equity and relevance. The facility survey and aanganwadi survey revealed that the services provided to women in the reproductive age group as well as children are of poor quality.

- Lack of trust on public health facilities due to unfriendly and hostile attitude of providers. This prevents the poor from utilizing public health facilities.

- Lack of co-ordination between various government departments: several departments under the ULB and the state government work towards the common goal of improving the life of urban poor. However, there is a lack

of co-ordination between the departments like Social Welfare, Social Defence, Health and Family Welfare, ICDS, Housing and Urban Planning which results in several lapses while providing services to the urban poor. There is a need for better communication and co-ordination between them so that the urban poor are effectively reached without duplication of human, time and financial resources.

- Lack of information about government schemes amongst the urban poor: A large number of urban poor are unaware of the government health schemes being implemented. Especially schemes like Chiranjeevi and Janani Suraksha Yojana which are aimed at reducing infant and maternal mortality amongst poor women are not well publicized and as a result many eligible women have not been able to take its benefits.
- Dearth of data and evidence about the health status of urban poor, especially basti-wise disaggregated data, is an important factor leading to inadequate health services for the poor.
- Lack of civic documents prevents urban poor to access public health services meant for families living below poverty line.
- Urban poor are not considered as equal partners in development and are left out of policy and programme planning and formulation.

6.2. Lessons Learnt

- The urban poor need integrated health services at their doorsteps rather than vertical programmes. There is a need for one-window approach so that health services can be accessed by the poor without having to spend time and money running from one health centre to another.
- There is a need for strong and efficient public health care delivery system in urban areas. Instead of diverting public funds to the private sector, government needs to strengthen the public health system. The proposed NUHM gives an opportunity to build a decentralized health care delivery system in urban areas which can ensure improved access of health services to the poor. But rather than focussing on empanelment of private providers, resources need to be spent on expanding and strengthening public health care facilities at the primary and secondary levels.
- Urban health policies and programmes can be effective if they are backed by data and evidence on the health status of the urban poor. It is very important

to build up a strong Health Information System which regularly guides the health interventions implemented by the government.

- When Government works in partnership with local organizations who understand people's needs, it results in better utilization of services. For example, through SAHAJ's interventions, the uptake of Chiranjeevi Scheme has increased and has reached poor pregnant women who really need the service. Partnership between Vadodara Municipal Corporation's Health department and organizations like SAHAJ will help in synergizing the strengths of each partner. Similar efforts are needed in formulation and implementation of new policies and programmes.
- There is a need for a separate division within the Department of Health and Family Welfare to oversee Urban Health programmes. This will ensure focused attention towards better outreach of health services as well as improvements in determinants of health in the urban areas.
- Inter-sectoral co-ordination within government at all levels is very important so that services effectively reach the poor. For example NURM and NUHM Department of Social Welfare and Social Defence, Housing, Urban Planning, ICDS need to co-ordinate with each other.
- Linking the poor with social health insurance to prevent further impoverishment that occurs due to escalating health care costs. The NUHM gives an opportunity to link the poor with health insurance by strategies of community risk pooling and promoting an urban health insurance model with subsidized premium for the urban poor. However, we urge that instead of commercial health insurance schemes, social health insurance needs to be promoted. The current CHCs promoted by SAHAJ can be absorbed as the Mahila Arogya Samitis to be set up under the NUHM.
- Building capacities of local people to advocate for their own rights ensures sustainability of health programmes.
- Community Development and Health Committees need constant support, hand holding and capacity building to ensure their sustained interest in local issues.

શહેરમાં કુપોષણ અને શિશુ સ્વાસ્થ્ય જેવા મહત્વના પ્રશ્ને તંત્રનું દુર્લક્ષ

■ ગરીબોના આરોગ્ય માટે સહજ શિશુ મિલાપે આવાજ ઉઠાવ્યો

(પ્રતિનિધિ દ્વારા) વડોદરા,તા.૭

શહેરમાં છેલ્લા ૨૫ વર્ષથી માતા અને નવજાત શિશુના સ્વાસ્થ્ય તથા સુરક્ષિત ગર્ભપાત જેવા મુદ્દાઓ પર કામ કરતી સંસ્થા સહજ શિશુ મિલાપ દ્વારા વડોદરામાં સ્લમ વિસ્તારોમાં આરોગ્ય સુવિધાઓ અને નવજાત શિશુ માટે પોષણની સુવિધાઓન હોવા સામે પોતાનો અવાજ બુલંદ કર્યો છે.

સંસ્થાના ટ્રસ્ટી રેણું ખન્નાએ જણાવ્યું હતું કે ભારત સરકાર દ્વારા રાષ્ટ્રીય શહેરી આરોગ્ય મિશનની જાહેરાત કરવામાં આવી છે જેમાં સમાવેશ કરવામાં આવેલા ૧૦૦ શહેરોમાં વડોદરાનો પણ સમાવેશ થાય છે. ત્યારે સમાજના નિચલા સ્તરે આરોગ્ય વ્યવસ્થા સુધરે તે તરફ સંસ્થા દ્વારા પ્રયત્નો હાથ ધરાયા છે.

સહજ શિશુ મિલાપ કેન્દ્ર ખાતે ઉપસ્થિત ૨૦ થી ૨૫ સંસ્થાની કાર્યકર્તા બહેનોએ તંત્રની નિષ્ક્રીયતા સામે રોષ ઠાલવ્યો હતો.સરજુ રાઠોડે જણાવ્યું હતું કે ચિરંજીવી યોજના સરકારે બહાર તો પાડી પણ તેનો લાભ લેવા માટે લાભાર્થીઓને તંત્ર દ્વારા ધક્કા ખવડાવવામાં આવે છે.પ્રસુતિના કેસ માટે મળતા રૂા.૬૦૦ માટે એયલા વધારે પડતાં પુરાવા માંગે છે કે અંતે ગરીબ લાભાર્થી યોજનાનો લાભ લેવાનું જ છોડી દે છે.રેહાના મણીયારે જણાવ્યું હતું કે વોર્ડ લેવલ પર બાળરોગ નિષ્ણાંતોની ભરતી થવી જોઈએ. દૂર દૂર આવેલી સરકારી હોસ્પિટલોમાં ધક્કા ખાઇ ખાઇને ઘણીવાર એવું પણ બને છે કે સારવારના અભાવે બાળકનુ મૃત્યું થઇ જાય છે.

ઈન્દુબેન બારિયા,સૈયદ યાસ્મીન,નસીમબેન અને અલ્પનાબેન નાઇએ જણાવ્યું હતુંકે કુપોષણ અટકાવવાં આંગણવાડીમાં ભોજન આપવામાં આવે છે પરંતુ તે એટલું ઉતરતી કક્ષાનું હોય છે કે ત પશુઓ પણ ખાય નહી,માતા મરણની નોંધ થવી જોઇએ અને તેની તપાસ થવી જોઇએ તેમજ રોગી કલ્યાણ સમિતિએ તેના ફંડનો ઉપયોગ ગરીબ દર્દીઓને મોંઘી દવા ખરીદી આપવામાં કરવો જોઇએ.

મહિલાઓ અને સરકારી અધિકારીઓ વચ્ચે સંવાદ

સહજ શિશુ મિલાપ સંસ્થા દ્વારા ગર્ભવતી મહિલાઓને આપવામાં આવતા લાભ અને તેમની સમસ્યા અંગે જનસંવાદ યોજાયો

સિટી રિપોર્ટર । વડોદરા

સરકાર દ્વારા ગરીબીની રેખા નીચે જીવતા લોકો માટે અનેક યોજનાઓ મૂકવામાં આવી છે, પણ તંત્રને કારણે ગરીબોને તેમના લાભ મળતા નથી. તેથી માતા બાળ આરોગ્ય અંગે કાર્યરત સહજ શિશુ મિલાપ સંસ્થા દ્વારા એક જનસંવાદ યોજાયો હતો. આ જનસંવાદમાં શહેરના વિવિધ સ્લમ વિસ્તારોમાંથી ૨૫૦ થી વધુ મહિલાઓએ હાજર સરકારી અધિકારીઓ સામે પોતાને ન મળતા હક અને લાભ વિશે સવાલો કર્યા હતા.

બાળ મૃત્યુદર ઓછા કરવા માટે સરકાર દ્વારા ગર્ભવતી મહિલાઓ માટે જનની સુરક્ષા યોજના અને ચિરંજવી યોજના મુકાઈ છે. પણ શહેરની કેટલીય મહિલાઓને આ લાભથી વંચિત રહે છે. તેથી સહજ શિશુ મિલાપ સંસ્થા દ્વારા શહેરની ફેમિલી એન્ડ કમ્યૂનિટી સાયન્સ ફેકલ્ટીના ઓડિટોરિયમમા જનસંવાદ યોજાયો હતો. આ જનસંવાદમાં યુ.સી.ડી. પ્રોજેક્ટ ઓફિસર ડો. મહેન્દ્ર રાજ અને શહેર વોર્ડ નં. ૧૧ ના લેડી મેડિકલ ઓફિસર ડો. સેજલ સોની અને વોર્ડ. ૧૦ ના લેડી મેડિકલ ઓફિસર ડો. જયશ્રી ખુબચંદાનીએ સ્લમ વિસ્તારની મહિલાઓએ અપૂરતી સુવિધાઓ વિશે પ્રશ્નો કર્યા હતા.

જનસંવાદમાં મહિલાઓએ પ્રશ્નો મૂક્યા હતા કે, અમને બીપીએલ કાર્ડ મળતાં નથી. અમારા વિસ્તારમાં આંગણવાડીનો અભાવ છે અને ક્યારેક આંગણવાડીના કાર્યકરોનો સહયોગ ન મળતા નથી. સરકારી ઓફિસોમા ધક્કા ખાવા પડે છે. જેના જવાબમાં ડો. મહેન્દ્રે મહિલાઓને સહયોગ આપવાની ખાતરી આપી હતી. તેમણે જણાવ્યું હતું કે, 'અમારા ૨૦૦૬ના સર્વેમાં માત્ર ૭૦ હજાર બીપીએલ પરિવારો નોંધાયા છે. તેમ છતાં, જેમને ન મળ્યાં હોય, તો આવકનો દાખલો આપીને મેળવી શકે છે.' મહિલાઓએ વોર્ડ લેડી મેડિકલ ઓફિસરો પર પણ જાગૃતિ ન ફેલાવવાના કારણે રોષ વ્યક્ત કર્યો હતો. કાર્યક્રમમા ડો.નીલિમા [illegible] ગર્ભવતી મહિલાઓને માર્ગદર્શન આપ્યુ હતુ.

Civic body embarks on facelift mission for urban medical services

HITARTH PANDYA
VADODARA, DECEMBER 4

THE Vadodara Municipal Corporation (VMC) has initiated a project to revamp the prevailing system of healthcare facilities in the city.

As part of the new project, the infrastructure of ward-wise health centres and family welfare centres will be converted into high-tech Urban Health Centres (UHC).

The project, which is a part of the National Urban Health Mission, has already gained momentum with detailed survey of the present setup and mapping of the city in terms of medical services.

"We have carried out the scientific survey of the city. It was not just a geographical survey of the city, but we have identified pockets, which are disease-prone. Even the slums have been identified so that extra precaution could be given in times of epidemic," said a senior VMC official.

According to senior VMC Health Department officials, the present health service system is scattered and there is a huge communication gap between the centres. The department still lacks computer networking since most centres do not have computers, leave alone the internal networking of the computers.

"It was necessary to first have a proper infrastructure and then go for the internal connectivity through computers. We have already identified certain places in the city," said a senior official.

The official added: "The site for the first UHC has already been finalised. Senior officials will have a look at the presentation, which will follow certain formalities, including sanctioning of funds. If all goes well, it will not take long for Vadodara to have its first UHC."

At present, the general hospitals are situated in different parts of the city at Navi Dharati slum quarters, Fatehpura, Mangleshwar, Makarpura, Manjalpur, Akota, Danteshwar, Sharad Nagar, Navapura, Tandalja, Gotri, Navayard and Bavchavad. They provide medical services to the affected people during epidemics and floods. Besides these hospitals, the VMC also has maternity homes, family welfare centres, family planning centres and laboratories.

The brain behind the entire concept, Dr Vikas Desai, Additional Director, Family Welfare, told *Newsline*: "The integrated approach to improve the urban healthcare in Vadodara is part of the National Urban Health Mission project and the VMC is showing a positive approach towards it. The focus is on the improved health services in the urban areas where the medical facilities are scattered."

Bal Sakha scheme floated to bring down infant mortality rate

GANDHINAGAR: The government has floated a Bal Sakha scheme under which new-born babies delivered by BPL (below poverty line) mothers in the state will be provided with free services of paediatricians. The scheme will be clubbed with the Chiranjeevi programme being already implemented across the state.

At the post-Cabinet meeting press briefing on Wednesday, the state government spokesman and Health Minister Jay Narayan Vyas said the Bal Sakha scheme was aimed at reducing the infant mortality rate (IMR) in the state, which at present is 136 among every 1,000 infants. The government is committed to bring the IMR to 100 by 2010.

Under the new scheme, the government will provide the assistance of Rs 5,000 to help poor mothers in availing the incubator facility for their new-born babies in case they develop complications after the birth. Besides, another Rs 300 will be given to them for availing paediatric services for their new-born babies, Vyas said. —*ENS*

The Indian EXPRESS
www.expressindia.com

Centre plans health insurance for urban poor

VIDYA KRISHNAN
NEW DELHI, NOVEMBER 25

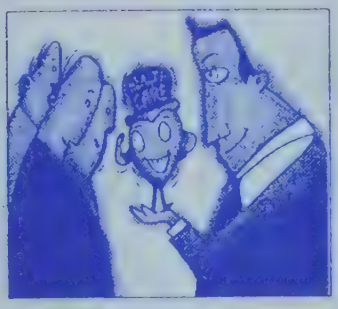
IF all goes well, the Union Health Ministry hopes to roll out its National Urban Health Mission, providing affordable health services and insurance to urban slum dwellers, within the next two months.

The project, which was set for an April launch, was temporarily shelved due to overlapping with the Rashtriya Swasthya Bima Yojana and the Jawaharlal Nehru National Urban Renewal Mission.

The Centre has set aside Rs 4,900 crore for the NUHM, which aims to target around 22 crore poor and homeless people in 429 cities. All cities with a population of above one lakh, state capitals and even district headquarters will be brought under its purview.

Close to six crore slum dwellers are expected to be provided health insurance under this programme. For the remaining population, the government will pay the first annual instalment of Rs 600 per person for a cover of Rs 50,000.

"Our beneficiaries can approach both public and private hospitals. We are also tying up insurance companies with private and public hospitals. We will ensure that there is one primary health centre



for every 40,000-50,000 slum dwellers," said Union Health Minister Anbumani Ramadoss.

The programme will be fully funded by the Centre in the first year of launch, but will require participation from state governments and local municipal bodies later.

The beneficiaries will be given a smart card which can be used in any empanelled hospital — public and private. The "Family Health Suraksha" cards will cover hospitalisation charges, surgical procedures as well as pre-existing diseases for a small premium.

"Another advantage in this programme is that the insurance money will be given directly to the hospitals, thereby ensuring availability of funds in hospitals for upgradation," said Ramadoss.

For every 100 households, there will be a Mahila Arogya Samiti to screen women for various disease. The seed money of Rs 5,000 for the Arogya Samiti will be given by the Centre initially, after which the Samiti will work as a self-help group.

An Urban Social Health Activist (USHA) will be deployed for every 5,000 persons. As many as 25,000 USHAs will be hired by 2012. And for every 50,000 persons, there will be an urban health centre with one doctor, two nurses and complete diagnostic facilities.

Annexure 2 Glossary

ANC	Antenatal Care
AW	Aanganwadi
AWW	Aanganwadi Worker
Bastis	Poor neighbourhoods, 'slums'
CDC	Community Development Committee
CHC	Community Health Committee
CDHO	Chief District Health Officer
CDPO	Community Development Programme Officer
HDI	Human Development Index
ICPD	International Conference on Population and Development
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
JSA	Jan Swasthya Abhiyan
RCH	Reproductive and Child Health
MCH	Maternal and Child Health
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PNC	Post Natal Care
PNDT	Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act- 1994
RTIs	Reproductive Tract Infections
STIs	Sexually Transmitted Infections
VUDA	Vadodara Urban Development Authority
ULB	Urban Local Body
WDR	World Development Report
WHO	World Health Organization

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Community Development Programme (2009)

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Smita Joshi	Field Officer
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Health Workers

Alpana Nayi	Jalaramnagar
Neeta Panchal	Bhesasurnagar
Neeru Padiyar	Gayatripura
Payal Rajput	Harinagar
Sarita Mali	Navinagari
Yasmeen Sayyed	Sahakarnagar I
Naseem Khilji	Sahakarnagar II
Sahana Sayyed	Sahakarnagar III
Rehana Maniyar	Vuda I
Indu Bariya	Vuda II
Manjula Solanki	Mujhmahuda I
Meena Mistry	Mujhmahuda II
Shakuntala Parmar	Mujhmahuda III
Sarju Rathod	Rampura

Health Committee Members

Sirajan Banu Shaikh	Vuda I
Nandu ben Bhuriya	Jalaramnagar
Kamla ben Vasava	Mujhmahuda II
Ayesha ben Shaikh	Sanjaynagar
Bhikha bhai Malik	Sahakarnagar

In the discourse on access to health services, the urban poor are missed out. Urbanisation is an increasing trend as rural migrants, many of whom are poor, arrive in cities and towns for jobs and in search for a better life. Many of them however end up in slums, or poor shanties, where life is literally a hand to mouth struggle. Doctors are available and so are medical services. But they are costly and unaffordable and worse unreliable. The slum doctors are at best quacks and if qualified, they are qualified quacks: irrational practice abounds as much as exploitation. Lack of clean water, toilets and housing as much as illiteracy and lack of assured public health services are the cause and the problem.

This report documents the experience of SAHAJ Shishu Milap in the bastis of Vadodara. The issues raised in this report are important in the context of the National Urban Health Mission, and the growing dispersal and invisibilisation of the urban poor.